Chapter 13

Legal Issues

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Introduction

This chapter discusses legal and ethical issues related to therapy with victims of child abuse.[1] For some abused children, therapy is ordered by a judge. For others, a social agency initiates treatment. For still others, the non-offending parent begins the therapeutic process. Several agencies may be interested in a child's progress, and it is not uncommon for therapists to be contacted by social workers, lawyers, and other professionals, each seeking information about the child. In addition, the therapist may be asked to testify in court and file reports with the judge. Therapy with abused children places unique pressures on the traditional therapist-client relationship; a relationship based squarely on confidentiality. The child's therapist balances the need for confidentiality against the legitimate interests of the agencies that are trying to help the child. The proper balance between confidentiality and disclosure is not always obvious. It is clear, however, that confidentiality should be respected to the extent confidentiality is compatible with the best interests of the child and the legitimate needs of the child protection system. General principles of confidentiality are discussed in detail in this chapter.

Confidentiality is not the only ethical conundrum facing therapists for abused children. The nature of the work raises the specter of dual roles. Here too, there are few easy answers, and the ethical principles discussed at the end of this chapter are intended to provide an ethical framework upon which professionals can build.

Professionals are urged to familiarize themselves regarding the requirements of the Americans with Disabilities Act. Further information can be found in the Disabilities chapter and on the Internet.[2]

In the final analysis, the best advice for professionals is to understand the ethical and legal requirements of the work, and to take reasonable, common sense steps. Most problems can be averted by proper planning. For example, therapists can clarify the boundaries of confidentiality before treatment begins. The potential for dual roles can be clarified at the outset.

California's Judicial System

California's highest court is the California Supreme Court. The Supreme Court has seven justices. Below the Supreme Court is the Court of Appeal, which is California's intermediate appellate court. California is divided into six appellate districts. There are nearly one hundred Court of Appeal justices. Below the Court of Appeal is the Superior Court. Every county has a Superior Court. In rural counties, there may be one or two Superior Court judges for the entire county. In large metropolitan areas, the Superior Court has dozens of judges.

The Superior Court conducts criminal and civil trials. In urban centers, the Superior Court is divided into divisions, including criminal, civil, family, probate, and juvenile. Superior Court judges are assigned to divisions for varying lengths of time. In rural counties, the Superior Court judge is a generalist, sitting one day on a criminal trial, the next day on a juvenile court matter, and the next on a civil case.

California does not have separate criminal courts, family courts, and juvenile courts.[3] Rather, criminal, family, and juvenile matters are the responsibility of the Superior Court. Although the Superior Court is responsible for judicial matters affecting abused and neglected children, the separation of the Superior Court into divisions leads to the common practice of referring to divisions as though they were separate courts.

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[1] Thanks to Gary C. Seiser, Senior Deputy County Counsel for San Diego County, who kindly reviewed this chapter and made many helpful suggestions.

[2] Two excellent places to start are: U.S. Department of Justice: http://www.usdoj.gov/crt/ada/adahom1.htm American Psychological Association: http://www.apa.org/pi/cdip/adainformation.html

[3] *See* California Welfare & Institutions Code § 245, which provides that "Each superior court shall exercise the jurisdiction conferred by this chapter, and while sitting in the exercise of such jurisdiction, shall be known and referred to as the juvenile court."

Thus, professionals often refer to Family Court, Juvenile Court, Criminal Court, or Probate Court. So long as it is clear that these "courts" are divisions of the Superior Court, there is no harm in these labels.

The Superior Court decides divorce and child custody cases under the California Family Code, and in such matters the Court is typically referred to as the Family Court. The Superior Court acts as a Juvenile Court when it is called on to protect children from abuse and neglect. Juvenile Court protective proceedings — called dependency proceedings — are decided under the California Welfare and Institutions Code.[4] In many counties, the Juvenile Court is located in a separate building. When a petition is filed in Juvenile Court to have a child protected, no other division of the Superior Court — including the Family Court — may determine the child's custody.[5]

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[4] For a description of the difference between Family Court and Juvenile Court see In re Chantal S., 13 Cal. 4th 196 (1996), where the court wrote:

> At the outset it is helpful to clarify the distinction between a "juvenile court," and its orders, and a "family court," and its orders. A "juvenile court" is a superior court exercising limited jurisdiction arising under juvenile law. Dependency proceedings in the juvenile court are special proceedings with their own set of rules, governed, in general, by the Welfare and Institutions Code. By contrast, "family court" refers to the activities of one or more superior court judicial officers who handle litigation arising under the Family Code. It is not a separate court with special jurisdiction, but is instead the superior court performing one of its general duties.

Id. at 200–201.

[5] California Welfare and Institutions Code § 304.

See In re Jennifer R., 14 Cal. App. 4th 704, 711 (1993) ("The juvenile court has exclusive jurisdiction to make custody orders over dependent children … .").

Informed Consent

Informed consent is a legal and ethical requirement for treatment.[6] Failure to obtain informed consent can constitute malpractice.[7] Consent should be obtained at the outset of treatment.[8] During treatment it may be necessary to revisit consent if conditions change.[9]

In genuine emergencies, treatment may be given without informed consent.[10]

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[6] *See* American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (found at 47 *American Psychologist* 1597–1611 (1992) (Principle 4.02(a) ("Psychologists obtain appropriate informed consent to therapy or related procedures … ."); National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.03(a) provides: "Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent.").

See also Cobbs v. Grant, 8 Cal. 3d 229, 242 (1972) ("a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment").

The requirement for informed consent grows out of respect for autonomy. Ruth R. Faden & Tom L. Beauchamp, *A History and Theory of Informed Consent* (1986) (New York: Oxford University Press). Clients should decide for themselves whether to enter therapy, and to make that decision intelligently, they need information about the nature, benefits, and risks of therapy, as well as alternatives to therapy. Joseph T. Smith, *Medical Malpractice: Psychiatric Care* (1986) (New York: John Wiley).

[7] *See* Cobbs v. Grant, 8 Cal. 3d 229, 240 (1972) ("the trend appears to be towards categorizing failure to obtain informed consent as negligence. … We agree with the majority trend").

See also Joseph T. Smith, *Medical Malpractice: Psychiatric Care* p. 160 (1986) (New York: John Wiley) ("Informed consent is a legal theory in medical malpractice which provides a patient a [right to sue] for not being adequately informed as to the nature and consequences of a particular medical procedure, process, or treatment prior to giving consent to the initiation of that treatment.").

[8] *See* American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 4.01(a): "Psychologists discuss with clients or patients as early as is feasible in the therapeutic relationship appropriate issues, such as the nature and anticipated course of therapy, fees, and confidentiality").

Harris notes that some mental health professionals worry that obtaining informed consent could interfere with therapy. E.A. Harris, The Importance of Risk Management in a Managed Care Environment. In M.B. Sussman (Ed.) *A Perilous Calling: The Hazards of Psychotherapy Practice* (1995). Harris writes:

> All practitioners should develop an informed consent policy that either is given to the patient in written form or is delivered orally and noted in one's records. … On first hearing this suggestion, many mental health providers express a fear that providing this information will damage the therapeutic relationship. … For the most part, these adverse consequences do not occur. Most patients are grateful to receive the information, and many consider it an aid, rather than a detriment to the therapeutic process.

Id. 252.

[9] *See* E.A. Harris, The Importance of Risk Management in a Managed Care Environment. In M.B. Sussman (Ed). *A Perilous Calling: The Hazards of Psychotherapy Practice* p. 253 (1995) ("With trauma victims in particular, informed consent is not a one-shot event, but rather an ongoing process of mutual information sharing and evaluation of risk.").

[10] *See* Stephen H. Behnke, James Preis & R. Todd Bates, *The Essentials of California Mental Health Law: A Straightforward Guide for Clinicians of All Disciplines* p. 117 (1998) (New York: W.W. Norton) ("A clinician may legally treat without informed consent only in emergency situations").

In addition to obtaining informed consent, therapists are encouraged to provide information regarding the therapist's education, training, and professional orientation.[11]

The elements of informed consent follow:

Competent

Competent adults can consent to treatment.[12] Neither mental illness nor need for psychotherapy render adults incapable of informed consent unless the illness significantly interferes with capacity to understand the nature of treatment.[13]

Informed consent for children is discussed later in this section.

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[11] *See* California Business and Professions Code § 4980.55, regarding marriage and family therapists, which provides:

> As a model for all therapeutic professions, and to acknowledge respect and regard for the consuming public, all marriage, family, and child counselors are encouraged to provide to each client, at an appropriate time and within the context of the psychotherapeutic relationship, an accurate and informative statement of the therapist's experience, education, specialities, professional orientation, and any other information deemed appropriate by the licensee.

See also Stephen H. Behnke, James Preis & R. Todd Bates, *The Essentials of California Mental Health Law: A Straightforward Guide for Clinicians of All Disciplines* (1998) (New York: W.W. Norton), where the authors write:

> In the first session you should cover all the matters that speak to the "frame" of the therapy. The frame consists of those aspects of your work that create the context in which the therapy takes place. The frame therefore includes the length of sessions, your per-session fee, whether you charge for missed sessions, whether you treat client vacations as missed sessions, whether you provide legal testimony, how you handle consultations and supervisions, whether you are available on an emergency basis, whether you accept phone calls at home, how often you bill, how you handle missed payments, what rules govern confidentiality, and the like.

Id. at 159.

[12] Adults are presumed competent to consent to treatment.

[13] Informed consent is required for patients who are involuntarily civilly committed. Regarding such commitments, California Welfare and Institutions Code § 5326.2 provides:

> To constitute voluntary informed consent, the following information shall be given to the patient in a clear and explicit manner:
>
> (a) The reason for treatment, that is, the nature and seriousness of the patient's illness, disorder or defect.
>
> (b) The nature of the procedures to be used in the proposed treatment, including its probable frequency and duration.
>
> (c) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.
>
> (d) The nature, degree, duration, and probability of the side effects and significant risks, commonly known by the medical profession, of such treatment, including its adjuvants, especially noting the degree and duration of memory loss (including its irreversibility) and how and to what extent they may be controlled, if at all.
>
> (e) That there exists a division of opinion as to the efficacy of the proposed treatment, why and how it works and its commonly known risks and side effects.
>
> (f) The reasonable alternative treatments, and why the physician is recommending this particular treatment.
>
> (g) That the patient has the right to accept or refuse the proposed treatment, and that if he or she consents, has the right to revoke his or her consent for any reason, at any time prior to or between treatments.

Voluntary
Consent must be voluntary. Consent is only voluntary if it is informed.[14] Consent is unlikely to be informed when the consent process is viewed as a "necessary evil" to be dispensed with as quickly as possible. Take the time to do it right.[15]

Purpose of Treatment
The client should be informed of the purpose of proposed treatment.[16] It is not necessary to give the client a detailed treatment plan. Reid observes that "[r]eviewing a detailed treatment plan with the patient is generally unnecessary unless the therapy carries unusual risk or controversy."[17]

Limits on Treatment
Financial or other limits on treatment should be discussed. The *Code of Ethics* of the National Association of Social Workers provides that clients should be informed of "limits to services because of the requirements of a third-party payer… ."[18]

Length of Treatment
Inform the client of the approximate time frame of treatment. The client should understand that consent given at the beginning of treatment extends throughout therapy, unless circumstances change.

Right to Refuse and Withdraw Consent
The client should be informed of the right to refuse consent. Additionally, the client should be informed of the right to withdraw consent and terminate treatment.[19]

When the client is court-ordered into treatment, the client should be informed of the possible legal consequences of refusing or withdrawing from treatment. When a court-ordered client balks at treatment, it may be a good idea to advise the client to consult an attorney about possible legal consequences. Needless to say, a therapist should not give legal advice.

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[14] *See* Cobbs v. Grant, 8 Cal. 3d 229 (1972) ("to be effective, [consent] must be an informed consent." *Id.* at 242. The client's right to informed consent "can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communication to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision." *Id.* at 245.).

[15] *See* William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed with Caution* p. 64 (1999) (Phoenix, AZ: Zeig & Tucker) ("When you get a formal consent, be sure it isn't merely a *pro forma* experience").

[16] *See* American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 4.01(a)).

[17] William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed with Caution* p. 27 (1999) (Phoenix, AZ: Zeig & Tucker).

[18] National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.03(a)).

[19] *See* National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.03(a)).

Risks
Inform the client of any risks of proposed treatment. It is not necessary to disclose every conceivable risk.[20] Inconsequential risks — especially minor risks that rarely occur — do not have to be disclosed.[21] In the context of medical treatment, the California Supreme Court wrote that "the patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required; the patient is concerned with the risk of death or bodily harm, and problems of recuperation. … [T]here is no physician's duty to discuss the relatively minor risks inherent in common procedures, when it is common knowledge that such risks inherent in the procedure are of very low incidence."[22] Discussing mental health treatment, Reid puts it this way: "When speaking of adverse effects of a treatment, for example, problems that are fairly rare but very dangerous should be included; those that are very common but benign should probably be mentioned; but those that are both rare and benign may be omitted."[23]

Hypnosis may adversely impact a client's ability to testify as a witness.[24] With clients who may need to testify, discuss the legal implications of hypnosis. In addition to hypnosis, techniques such as sodium amytal may impact a client's testimony.

A therapist using experimental or controversial techniques should inform the client.

Naturally, psychiatrists prescribing drugs adhere to consent procedures regarding medication.

Benefits
Discuss likely benefits of treatment.

Alternatives
Discuss alternatives to the proposed treatment, including no treatment.[25]

Limits of Confidentiality
"Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant."[26] The client should be informed of

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[20] See William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed with Caution* (1999) (Phoenix, AZ: Zeig & Tucker). Reid writes that "Reviewing a detailed treatment plan with the patient is generally unnecessary unless the therapy carries unusual risk or controversy. Side effects or adverse effects that are both rare and benign need not be exhaustively listed." *Id.* at 27. Reid continues that consent "does not require every shred of available data or information that is so esoteric that it is unlikely to matter in the case at hand." *Id.* at 76.

[21] The case of *Cobbs v. Grant*, 8 Cal. 3d 229 (1972) is a leading authority on the law of informed consent. In *Cobbs v. Grant*, the California Supreme Court wrote that "a disclosure need not be made if the procedure is simple and the danger remote and commonly appreciated to be remote." *Id.* at 245.

[22] Cobbs v. Grant, 8 Cal. 3d 229, 244 (1972).

[23] William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed with Caution* p. 77 (1999) (Phoenix, AZ: Zeig & Tucker).

[24] California Evidence Code § 795.

[25] *See* Cobbs v. Grant, 8 Cal. 3d 229, 242–243 (1972) ("it is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie. To enable the patient to chart his course knowledgeably, reasonable familiarity with the therapeutic alternatives and their hazards becomes essential").

[26] American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 5.01(b)).

foreseeable limits on confidentiality.[27] California's child abuse reporting law, for example, overrides confidentiality.[28] The Committee on Professional Practice of the American Psychological Association notes that "[i]t is advisable at the outset of treatment to inform your clients that the usual rule concerning confidentiality does not apply when the duty to report child abuse arises."[29] Kremer and Gesten provide useful information on confidentiality in managed care.[30]

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[27] *See* National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.07(e) ("Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship.").

See also California Rule of Court 1257.3, which sets standards for court-ordered child custody evaluations, and which requires evaluators to inform individuals of limits on confidentiality.

[28] *See* People v. Stritzinger, 34 Cal. 3d 505, 512 (1983) ("The Legislature obviously intended to provide a specific exception to the general privileges set out in the Evidence Code so that incidents of child abuse might be promptly investigated and prosecuted.").

See also M.L. Deed, Mandated Reporting Revisited: *Roe v. Superior Court*, 14 *Law and Policy* 219–239 (1993).

[29] Committee on Professional Practice and Standards, A Committee of the Board of Professional Affairs of the American Psychological Association, Twenty-Four Questions (and Answers) About Professional Practice in the Area of Child Abuse, 26 *Professional Psychology: Research and Practice* 377–385, at 378 (1995).

[30] Thomas G. Kremer and Ellis L. Gesten. (1998). Confidentiality Limits of Managed Care and Clients' Willingness to Self-Disclose. *Professional Psychology: Research and Practice, 29,* 553–558. Kremer and Gesten write:

> To ensure ethical practice under managed care, psychologists may be required to take extra steps to see that their clients are fully informed of confidentiality limits and of treatment limitations. The psychologist should be an active, but transparent, participant between the client and the managed care organization, neither hiding nor promoting requirements and restrictions. This permits managed care practices to be properly attributed to the oversight organization, rather than the psychologist, and allows clients to make informed decisions about disclosure. Some suggestions for working with managed care clients are outlined here:
>
> 1. Provide your clients with a first session discussion of the information requirements and utilization review practices governing their therapy.
> 2. Be certain your clients are informed by actively questioning their understanding of requirements and practices.
> 3. If the managed care organization provides forms that delineate requirements and procedures, carefully review them with your clients before signing.
> 4. Inform your clients about potential repercussions from disclosure of sensitive material.
> 5. Plan for utilization review, provide only the necessary minimum of information required to secure appropriate treatment for your clients — avoid dramatic details and extensive explications.
> 6. Advocate for your clients by working to change managed care practices which limit or interfere with treatment.
> 7. Always document interactions with utilization reviewers or managed care officials.

Id. at 557.

Fee

The client must be informed of "the fee to be charged for the professional services, or the basis upon which that fee will be computed."[31]

Status as Trainee or Supervisee

The client should be informed if the professional is a student, intern, trainee, or supervisee.[32]

Opportunity to Ask Questions

Encourage the client to ask questions about the consent process.

Is it Ever Permissible to Withhold Information from a Client?

In rare cases, the therapist may believe full disclosure of risks could frighten a fragile person into refusing much needed care.[33] Reid addresses this concern by writing that "[u]nder special circumstances, it is permissible to keep information about adverse effects from a patient, for example, when a doctor believes a treatment is very important and the risk-benefit ratio is very favorable, but the patient would be so frightened by the discussion that he or she would not be able to judge the potential benefit rationally. Although this situation is not uncommon in severely and chronically mentally ill patients (for example, those who require antidepressants, electroconvulsive therapy [ECT], or antipsychotic drugs to alleviate morbid depression or psychosis), nonmedical psychotherapists should only rarely consider depriving the patient of information about adverse effects."[34]

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[31] California Business and Professions Code § 4982(n) (governing marriage and family therapists; it is unprofessional conduct to fail to disclose the fee charged or the basis for computing the fee); California Business and Professions Code § 4992.3(n) (social workers).

[32] *See* American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 4.01(b): "When the psychologist's work with clients or patients will be supervised, the [discussion of therapy] includes that fact, and the name of the supervisor, when the supervisor has legal responsibility for the case." "When the therapist is a student intern, the client or patient is informed of that fact.").

See also William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed with Caution* p. 51 (1999) (Phoenix, AZ: Zeig, Tucker & Co.) ("The supervisor should discuss supervision rules and contingency plans for problems in advance, and the patient should be made generally (but not obsessively) aware that a highly trustworthy and qualified third person will have access to clinical information.").

[33] *See* Cobbs v. Grant, 8 Cal. 3d 229 (1972). The California Supreme Court wrote:

> A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent. For this reason the law provides that in an emergency consent is implied, and if the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest available relative.

Id. at 243. The court continued:

> A disclosure need not be made beyond that required within the medical community when a doctor can prove by a preponderance of the evidence he relied upon facts which would demonstrate to a reasonable man the disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment.

Id. at 246.

[34] William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed with Caution* pp. 27–28 (1999) (Phoenix, AZ: Zeig & Tucker).

Video or Audio Recording
Consent should be obtained to audio or videotape treatment sessions.[35]

Informed Consent for Forensic Evaluation

Is informed consent required for purely forensic evaluation, where no treatment is provided? Because the principle of informed consent is based on respect for autonomy, the answer should normally be yes. In certain court-ordered evaluations, informed consent may not be necessary. Even in court-ordered cases, however, professionals are encouraged to inform clients of the nature of services to be provided, and, where possible, to obtain informed consent.[36] The American Academy of Psychiatry and the Law's *Ethical Guidelines for the Practice of Forensic Psychiatry* provide that "[t]he informed consent of the subject of a forensic evaluation is obtained when possible. Where consent is not required, notice is given to the evaluee of the nature of the evaluation. If the evaluee is not competent to give consent, substituted consent is obtained in accordance with the laws of the jurisdiction."[37] Along similar lines, the American Psychological Association's *Speciality Guidelines for Forensic Psychologists* provide:

> Forensic psychologists have an obligation to ensure that prospective clients are informed of their rights with respect to the anticipated forensic service, of the purposes of any evaluation, of the nature of procedures to be employed, of the intended uses of any product of their services, and of the party who has employed the forensic psychologist. Unless court ordered, forensic psychologists obtain informed consent of the client or party, or their legal representative, before proceeding with such evaluations and procedures.[38]

The American Psychological Association's *Guidelines for Child Custody Evaluations in Divorce Proceedings* state that "[t]he psychologist obtains informed consent from all adult participants and, as appropriate, informs child participants."[39]

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[35] *See* American Association for Marriage and Family Therapy, *Code of Ethics* (1991) (Standard 1.8: "Marriage and family therapists obtain written informed consent from clients before videotaping, audio recording, or permitting third party observation"); American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 5.01(c): "Permission for electronic recording of interviews is secured from clients and patients"); National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.03(f): "Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party.").

[36] *See* National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.03(d) provides: "In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse services.").

[37] American Academy of Psychiatry and the Law, Ethical Guidelines for the Practice of Forensic Psychiatry. In *Membership Directory of American Academy of Psychiatry and the Law* (1995) (Guideline III).

[38] American Psychological Association, Committee on Ethical Guidelines for Forensic Psychologists, Speciality Guidelines for Forensic Psychologists, 15 *Law and Human Behavior* 655–665 (1991) (Guideline IV. E).

[39] American Psychological Association, Guidelines for Child Custody Evaluations in Divorce Proceedings, 49 *American Psychologist* 677–680 (1994) (Guideline III, paragraph 8).

Informed Consent for Children

Children are legally incapable of consenting to most forms of treatment.[40] A child is a person under the age of eighteen.[41] Thus, informed consent is normally obtained from one or both parents.[42] A parent's right to consent to treatment is part of the parent's right to legal custody of the child.[43] Generally, both parents have legal custody, and both have the right to consent to treatment for their child.[44]

Never Married Parents

Parents who never married share legal custody.[45] If one parent dies, refuses, or is unable to take custody, or abandons the child, the other parent has custody.[46] Generally, the consent of one parent is sufficient for treatment.

Married Parents

Married parents share legal custody, and each parent has authority to consent to treatment for their child. Generally, the consent of one married parent is sufficient.

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[40] *See* American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992). Standard 4.02 provides in part:

> (b) When persons are legally incapable of giving informed consent, psychologists obtain informed permission from a legally authorized person, if such substitute consent is permitted by law.
>
> (c) In addition, psychologists (1) inform those persons who are legally incapable of giving informed consent about the proposed interventions in a manner commensurate with the persons' psychological capacities, (2) seek their assent to those interventions, and (3) consider such persons' preferences and best interests.

[41] California Family Code § 6500 provides that "A minor is an individual who is under 18 years of age." California Family Code § 7505 provides that "The authority of a parent ceases on any of the following: (a) The appointment, by a court, of a guardian of the person of the child. (b) The marriage of the child. (c) The child attaining the age of majority."

[42] *See* Renee Tankenoff Brant & Jonathan Brant, Child and Adolescent Therapy, in Lawrence E. Lifson & Robert I. Simon (Eds.), *The Mental Health Practitioner and the Law: A Comprehensive Handbook* pp. 72–8, at 74 (1998) (Cambridge, MA: Harvard University Press), where the authors write:

> While parents or guardians are legally required to give informed consent for treatment, a child therapist should also try to inform the child or adolescent about the treatment process and enlist the child's cooperation and assent in a manner consistent with developmental and therapeutic considerations.

See also American Medical Association, *The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry* Section 4, ¶ 7 (1998) ("Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time, the psychiatrist must assure the minor proper confidentiality."); Marilyn Berner, Informed Consent, in Lawrence E. Lifson & Robert I. Simon (Eds.), *The Mental Health Practitioner and the Law* pp. 24-4, at 41 (1998) (Cambridge, MA: Harvard University Press) ("Contrary to the general rule for adults, children are presumed to be incompetent to consent to treatment; their parents exercise those rights for them.").

[43] *See* California Family Code §§ 3003, 3006.

[44] *See* Renee Tankenoff Brant & Jonathan Brant, Child and Adolescent Therapy, in Lawrence E. Lifson & Robert I. Simon (Eds.), *The Mental Health Practitioner and the Law* pp. 72–88, at 73 (1998) (Cambridge, MA: Harvard University Press) ("In the case of an intact two-parent family, either parent may consent to treatment of a child or adolescent (and thereby incur legal responsibility for paying for the services). A single parent can also obviously consent to treatment for a child. Whenever a therapist sees a child or adolescent whose parents are divorced or legally separated, the therapist must be aware of the legal custodial arrangements concerning the child.").

[45] California Family Code § 3010(a). A child's biological mother automatically has legal custody. The father has legal custody if he is what the law calls the presumed father under Section 7611 of the Family Code. A man is a presumed father if he is determined by laboratory tests to be the father, if he was married to the child's mother and the child was born during the marriage or within 300 days after the marriage terminated, and in other circumstances set forth in Section 7611.

[46] California Family Code § 3010(b).

Divorced Parents

When parents divorce, the divorce decree determines whether they have joint or sole legal custody. When divorced parents have joint legal custody, they "share the right and the responsibility to make the decisions relating to the health, education, and welfare of [their] child."[47] When the divorce decree gives one parent sole legal custody, that parent alone has authority to consent to treatment.[48]

With divorced parents, the therapist should determine who has authority to consent for the child. If both parents consent, there is no problem. If only one divorced parent requests treatment, make sure the requesting parent has legal custody. If not, get consent from the parent with legal custody. If in doubt, especially if divorced parents disagree about therapy for their child, you may wish to examine the divorce decree, speak to the parents' lawyers, speak to your own lawyer, decline treatment, or try to help the parents reconcile their differences regarding treatment.[49]

Who Consents for Abused and Neglected Children Involved with the Juvenile Court?

A child who is involved with the Juvenile Court may be living with parents, with other relatives, in a foster home, or in another out-of-home placement.[50] Mental health treatment for the child may be initiated by parents, by the child's social worker, by order of the Juvenile Court, and in other ways. Given the variety of routes to the therapist's office, and the different adults involved in the child's life, it can be difficult to determine who has authority to consent to therapy for the child.

At the outset, it is important to understand that parents do not lose the right to consent or withhold consent simply because their child is involved with the Juvenile Court.[51] Moreover, a child's involvement with the Juvenile Court does not automatically bestow consent authority on social workers, foster parents, or relatives other than parents.

When a mental health professional is invited to treat a child involved with the Juvenile Court, the following guidelines are offered. Parental consent is preferred, and should be obtained in advance. If the child has a social worker, the therapist can ask the worker to contact the parents, and to request the parents to communicate with the therapist about consent. Prior to beginning therapy, the therapist should obtain copies of court orders regarding the child's care and custody, and should discuss with the social worker any pros or cons of involving the parents in the consent process.

When parents cannot be located, are incompetent, or are unwilling to consent to treatment for their child, the best course of action is usually to obtain a Juvenile Court order authorizing treatment and dispensing with parental consent. The order may be obtained by the child's attorney, county counsel, or the child's social worker. In some communities, procedures already exist for such orders. The judge's order may authorize the social worker, a *guardian ad litem*, or another responsible adult to consent to treatment.

When a child is a dependent of the court under Section 300 of the Welfare and Institutions Code, and the child has been removed from the physical custody of the parents, only a juvenile court judicial officer has

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[47] California Family Code § 3003.

[48] *See* California Family Code § 6903. Regarding medical care, Section 6903 states that "'Parent or guardian' means either parent if both have legal custody, or the parent or person having legal custody, or the guardian, of a minor."

[49] By trying to help parents resolve their differences regarding treatment for their child, you may unwittingly enter into a therapist-client relationship with the *parents*. If that is not your desire, be clear about it with the parents.

[50] The child may be in temporary custody pending proceedings in Juvenile Court, or the child may be a dependent of the court following adjudication.

[51] *See* California Welfare & Institutions Code § 369. Section 369 deals with "medical, surgical, dental, or other remedial care" for children taken into temporary protective custody, and for children who are dependents of the Juvenile Court. Section 369 clearly contemplates parental involvement in decision making about the child's treatment. Only when parents are unable or unwilling to make responsible decisions for their child does the Juvenile Court authorize treatment.

authority to make orders regarding administration of psychotropic medications for the child.[52] "The juvenile court may issue a specific order delegating this authority to a parent upon making findings on the record that the parent poses no danger to the child and has the capacity to authorize psychotropic medications."[53]

Guardian

When a child has no parent who is willing or able to care for the child, a Superior Court judge may appoint a guardian. A child's guardian may consent to medical or mental health care. Formal guardianship is uncommon. Children whose parents are divorced do not need a guardian because one or both parents have legal custody of the child.

Guardian ad litem

Guardian ad litem has two meanings. First, children cannot start lawsuits or be sued in their own name. Thus, when a child is sued or starts a lawsuit, the court appoints a *guardian ad litem* for purposes of the litigation.[54] Second, a Juvenile Court judge appoints a *guardian ad litem* for an abused or neglected child.[55] A *guardian ad litem* is not a "guardian" as described in the preceding paragraph, and a *guardian ad litem* does not have authority to consent to medical care unless so authorized by a judge.

Informed Consent by Children

California law allows children to consent to treatment in the situations described below. When the child is authorized to consent, parental consent is unnecessary.[56]

Mental Health Treatment

Section 6924 of the California Family Code provides that a child who is twelve or older may consent to outpatient mental health treatment or counseling if two requirements are satisfied.[57] First, the professional determines that the child is mature enough to participate intelligently in treatment. Second, the child is either (a) an alleged victim of child abuse or incest, or (b) the child presents a danger of serious physical or mental harm to self or to others unless treated.

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[52] California Welfare & Institutions Code § 369.5.

[53] California Welfare & Institutions Code § 369.5(a).

[54] California Code of Civil Procedure § 372.

[55] See Gary C. Seiser & Kurt Kumli, *California Juvenile Courts Practice and Procedure* § 2.66 (2001) (Lexis Pub.).

[56] *See* California Family Code § 6920. Section 6920 is in the chapter of the Family Code that deals with consent by minors. Section 6920 states that "Subject to the limitations in this chapter, notwithstanding any other provisions of law, a minor may consent to the matters provided in this chapter, and the consent of the minor's parent or guardian is not necessary."

[57] *See* California Family Code § 6924 which provides:

> (a) As used in this section:
>
> (1) "Mental health treatment or counseling services" means the provision of mental health treatment or counseling on an outpatient basis by any of the following:
>
> (A) A governmental agency.
>
> (B) A person or agency having a contract with a governmental agency to provide the services.
>
> (C) An agency that receives funding from community united funds.
>
> (D) A runaway house or crisis resolution center.
>
> (E) A professional person, as defined in paragraph (2).

Under Section 6924, parents must be informed of treatment unless the professional determines that parental involvement would be inappropriate.[58] The professional is required to state in the child's record (1) whether and when the professional attempted to contact the child's parent, (2) whether the attempt was successful, or (3) the reason why the professional decided it would be inappropriate to contact the parent.

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(2) "Professional person" means any of the following:

(A) A person designated as a mental health professional in Sections 622 to 626, inclusive, of Article 8 of Subchapter 3 of Chapter 1 of Title 9 of the California Code of Regulations.

(B) A marriage and family therapist as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.

(C) A licensed educational psychologist as defined in Article 5 (commencing with Section 4986) of Chapter 13 of Division 2 of the Business and Professions Code.

(D) A credentialed school psychologist as described in Section 49424 of the Education Code.

(E) A clinical psychologist as defined in Section 1316.5 of the Health and Safety Code.

(F) The chief administrator of an agency referred to in paragraph (1) or (3).

(G) A marriage and family therapist registered intern, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, while working under the supervision of a licensed professional specified in subdivision (f) of Section 4980.40 of the Business and Professions Code.

(3) "Residential shelter services" means any of the following:

(A) The provision of residential and other support services to minors on a temporary or emergency basis in a facility that services only minors by a governmental agency, a person or agency having a contract with a governmental agency to provide these services, an agency that receives funding from community funds, or a licensed community care facility or crisis resolution center.

(B) The provision of other support services on a temporary or emergency basis by any professional person as defined in paragraph (2).

(b) A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if both of the following requirements are satisfied:

(1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services.

(2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse.

(c) A professional person offering residential shelter services, whether as an individual or as a representative of an entity specified in paragraph (3) of subdivision (a), shall make his or her best efforts to notify the parent or guardian of the provision of services.

(d) The mental health treatment or counseling of a minor authorized by this section shall include involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person who is treating or counseling the minor shall state in the client record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

(e) The minor's parents or guardian are not liable for payment for mental health treatment or counseling services provided pursuant to this section unless the parent or guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian. The minor's parents or guardian are not liable for payment for any residential shelter services provided pursuant to this section unless the parent or guardian consented to the provision of those services.

(f) This section does not authorize a minor to receive convulsive therapy or psychosurgery as defined in subdivisions (f) and (g) of Section 5325 of the Welfare and Institutions Code, or psychotropic drugs without the consent of the minor's parent or guardian.

[58] California Family Code § 6924(d).

The child's parents are not responsible to pay for treatment provided under Section 6924 unless the parents participate in the treatment.[59]

Section 6924 does not authorize a child to consent to psychotropic drugs, convulsive therapy, or psychosurgery.[60]

Consent to Medical Treatment by Alleged Rape Victim

The Family Code provides that a child who is twelve years old or older, and who is alleged to have been raped, may consent to medical diagnosis and treatment related to the offense.[61] The Penal Code sets forth minimum standards for the examination and treatment of victims of sexual assault and child molestation.[62] The Penal Code states that "In cases of known or suspected child abuse, the consent of the parents or legal guardian is not required. In the case of suspected child abuse and nonconsenting parents, the consent of the local agency providing child protective services or the local law enforcement agency shall be obtained. Local procedures regarding obtaining consent for the examination and treatment of, and the collecting of evidence from, children from child protective authorities shall be followed."[63]

Consent to Medical Treatment by Alleged Victim of Sexual Assault

A child of any age who is alleged to have been sexually assaulted may consent to medical care related to the diagnosis and treatment of the condition.[64]

Consent to Pregnancy Treatment

A minor may consent to medical treatment related to prevention and treatment of pregnancy.[65]

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[59] California Family Code § 6924(e).

[60] California Family Code § 6924(f).

[61] California Family Code § 6927 provides that "A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape."

[62] California Penal Code § 13823.11.

[63] California Penal Code § 13823.11(5).

[64] California Family Code § 6928 provides:

> (a) "Sexually assaulted" as used in this section includes, but is not limited to, conduct coming within Section 261, 286, or 288a of the Penal Code.
>
> (b) A minor who is alleged to have been sexually assaulted may consent to medical care related to the diagnosis and treatment of the condition, and the collection of medical evidence with regard to the alleged sexual assault.
>
> (c) The professional person providing medical treatment shall attempt to contact the minor's parent or guardian and shall note in the minor's treatment record the date and time the professional person attempted to contact the parent or guardian and whether the attempt was successful or unsuccessful. This subdivision does not apply if the professional person reasonably believes that the minor's parent or guardian committed the sexual assault on the minor.

[65] California Family Code § 6925 provides:

> (a) A minor may consent to medical care related to the prevention or treatment of pregnancy.
>
> (b) This section does not authorize a minor:
>
> (1) To be sterilized without the consent of the minor's parent or guardian.
>
> (2) To receive an abortion without the consent of a parent or guardian other than as provided in Section 123450 of the Health and Safety Code.

Consent to Abortion

A pregnant minor may consent to an abortion.[66]

Consent to Treatment for Communicable Disease

A child who is twelve years old or older may consent to diagnosis and treatment related to communicable diseases, including sexually transmitted diseases.[67]

Consent to HIV Test

A child who is twelve years old or older may consent to testing for HIV.[68]

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[66] *See* American Academy of Pediatrics v. Lungren, 16 Cal. 4th 307 (1997).

[67] California Family Code § 6926 provides:

> (a) A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer, or is a related sexually transmitted disease, as may be determined by the State Director of Health Services.
>
> (b) The minor's parents or guardian are not liable for payment for medical care provided pursuant to this section.

[68] California Health and Safety Code § 121020(a)(1) provides:

> (a) (1) When the subject of an HIV test is not competent to give consent for the test to be performed, written consent for the test may be obtained from the subject's parents, guardians, conservators, or other person lawfully authorized to make health care decisions for the subject. For purposes of this paragraph, a minor shall be deemed not competent to give consent if he or she is under 12 years of age.
>
> (2) Notwithstanding paragraph (1), when the subject of the test is a minor adjudged to be a dependent child of the court pursuant to Section 360 of the Welfare and Institutions Code, written consent for the test to be performed may be obtained from the court pursuant to its authority under Section 362 or 369 of the Welfare and Institutions Code.
>
> (b) Written consent shall only be obtained for the subject pursuant to subdivision (a) when necessary to render appropriate care or to practice preventative measures.
>
> (c) The person authorized to consent to the test pursuant to subdivision (a) shall be permitted to do any of the following:
>
> (1) Notwithstanding Sections 120975 and 120980, receive the results of the test on behalf of the subject without written authorization.
>
> (2) Disclose the test results on behalf of the subject in accordance with Sections 120975 and 120980.
>
> (3) Provide written authorization for the disclosure of the test results on behalf of the subject in accordance with Sections 120975 and 120980.

Drug and Alcohol Treatment

A child who is twelve years old or older may consent to drug and alcohol treatment.[69]

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[69] California Family Code § 6929 provides:

(a) As used in this section:

(1) "Counseling" means the provision of counseling services by a provider under a contract with the state or a county to provide alcohol or drug abuse counseling services pursuant to Part 2 (commencing with Section 5600) of Division 5 of the Welfare and Institutions Code or pursuant to Division 10.5 (commencing with Section 11750) of the Health and Safety Code.

(2) "Drug or alcohol" includes, but is not limited to, any substance listed in any of the following:

(A) Section 380 or 381 of the Penal Code.

(B) Division 10 (commencing with Section 11000) of the Health and Safety Code.

(C) Subdivision (f) of Section 647 of the Penal Code.

(3) "LAAM" means levoalphacetylmethadol as specified in paragraph (10) of subdivision (c) of Section 11055 of the Health and Safety Code.

(4) "Professional person" means a physician and surgeon, registered nurse, psychologist, clinical social worker, or marriage, family, and child counselor.

(b) A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem.

(c) The treatment plan of a minor authorized by this section shall include the involvement of the minor's parent or guardian, if appropriate, as determined by the professional person or treatment facility treating the minor. The professional person providing medical care or counseling to a minor shall state in the minor's treatment record whether and when the professional person attempted to contact the minor's parent or guardian, and whether the attempt to contact the parent or guardian was successful or unsuccessful, or the reason why, in the opinion of the professional person, it would not be appropriate to contact the minor's parent or guardian.

(d) The minor's parents or guardian are not liable for payment for any care provided to a minor pursuant to this section, except that if the minor's parent or guardian participates in a counseling program pursuant to this section, the parent or guardian is liable for the cost of the services provided to the minor and the parent or guardian.

(e) This section does not authorize a minor to receive replacement narcotic abuse treatment, in a program licensed pursuant to Article 3 (commencing with Section 11875) of Chapter 1 of Part 3 of Division 10.5 of the Health and Safety Code, without the consent of the minor's parent or guardian.

(f) It is the intent of the Legislature that the state shall respect the right of a parent or legal guardian to seek medical care and counseling for a drug- or alcohol-related problem of a minor child when the child does not consent to the medical care and counseling, and nothing in this section shall be construed to restrict or eliminate this right.

(g) Notwithstanding any other provision of law, in cases where a parent or legal guardian has sought the medical care and counseling for a drug- or alcohol-related problem of a minor child, the physician shall disclose medical information concerning such care to the minor's parents or legal guardian upon their request, even if the minor child does not consent to disclosure, without liability for such disclosure.

Medical and Dental Care — Fifteen and Older Living Separately

A minor who is fifteen years old or older may consent to medical or dental care if: (1) the minor is living separate and apart from the parents, with or without the parent's consent, and (2) the minor is managing her or his own financial affairs, regardless of the source of the minor's income.[70] The physician or dentist may contact the parents.

Emancipated Minors

For purposes of informed consent, an emancipated minor is treated as an adult.[71] A minor is emancipated in three ways: (1) by getting married, (2) by serving on active duty in the military, or (3) by obtaining a declaration of emancipation from a court.[72]

Confidentiality and Privilege

Confidentiality is essential to psychotherapy.[73] This section discusses legal and ethical dimensions of confidentiality. There are three sources of confidentiality: (1) the ethical obligation to protect confidential client information, (2) state and federal laws that make client records confidential, and (3) privileges that apply in legal proceedings.

The Ethical Duty to Protect Confidential Information

Ethics codes of professional associations place a premium on confidentiality. The *Code of Ethics* of the American Professional Society on the Abuse of Children provides that "[t]he right of clients to confidentiality, which is the assurance that nothing about an individual is revealed except under agreed-upon conditions, is fundamental to professional relationships with clients."[74] The American Psychological Association's *Code of Conduct* states that "psychologists have a primary obligation to take reasonable precautions to respect the confidentiality rights of those with whom they work or consult."[75] The *Code of Ethics* of the National Association of Social Workers provides that "social workers should protect the confidentiality of all information obtained in the course of professional services, except for compelling professional reasons."[76]

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[70] California Family Code § 6922 provides:

> (a) A minor may consent to the minor's medical care or dental care if all of the following conditions are satisfied:
>
> (1) The minor is 15 years of age or older.
>
> (2) The minor is living separate and apart from the minor's parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence.
>
> (3) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income.
>
> (b) The parents or guardian are not liable for medical care or dental care provided pursuant to this section.
>
> (c) A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian.

[71] *See* California Family Code § 7050(e)(1). An emancipated minor is considered an adult for purposes of consenting "to medical, dental, or psychiatric care … ."

[72] *See* California Family Code §§ 7000 to 7143.

[73] *See* People v. Stritzinger, 34 Cal. 3d 505, 514 (1983) (the value of mental health treatment "is bottomed on a confidential relationship").

See also American Medical Association, *The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry* (1998) (Section 4, ¶ 1: "Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment.").

[74] American Professional Society on the Abuse of Children, *Code of Ethics* (1997).

[75] American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 5.02).

[76] National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.07(c)).

The *Principles of Medical Ethics* of the American Medical Association require physicians to "safeguard patient confidences within the constraints of the law."[77]

Violation of the ethical duty of confidentiality can lead to three types of proceedings against a professional. First, a member of a professional association who violates the association's code of ethics can be disciplined or expelled. Second, state licensing authorities may institute disciplinary proceedings to limit, suspend, or revoke the professional's license.[78] Third, a client whose confidentiality is breached can sue the professional.

Laws that Make Records Confidential

California, like other states, has numerous laws making records confidential.[79] Of particular importance to mental health professionals is California's Confidentiality of Medical Information Act (CMIA).[80] CMIA applies to mental health and medical records.[81] CMIA provides that mental health professionals may not disclose information regarding clients without client authorization, unless disclosure is required by law.[82] CMIA is discussed later in this section under the heading "Disclosure of Confidential and Privileged Information."

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[77] American Medical Association, *Principles of Medical Ethics* (1989).

[78] *See* California Business and Professions Code § 4982(m) (Marriage and Family Therapists; unprofessional conduct includes: "Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means."); California Business and Professions Code § 4992.3(m) (Social Workers; unprofessional conduct includes: "Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means."); California Business and Professions Code § 2960(h) (Psychologists: grounds for disciplinary action include: "Willful, unauthorized communication of information received in professional confidence.").

See also Barclays Official California Code of Regulations, vol. 21, Title 16, § 1858(k) (Educational Psychologists; unprofessional conduct when an educational psychologist "Fails to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client during the course of treatment and all information about the client which is obtained from tests or other such means."); *id.* § 1881(I) (Licensed Clinical Social Workers; unprofessional conduct when an LCSW "Fails to maintain the confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client during the course of treatment and all information about the client which is obtained from tests or other such means.").

Complaints to licensing boards should be taken very seriously, and defended vigorously. *See Bancroft-Whitney's California Civil Practice*, Vol. 3, § 34.3 (1992) (San Francisco, CA: Bancroft-Whitney) ("Complaints made to disciplinary or regulatory bodies should be vigorously defended since an adverse ruling can raise issues of collateral estoppel or res judicata.").

[79] Records of the juvenile court are confidential. *See* California Welfare and Institutions Code § 827.

[80] California Civil Code § 56 et seq.

[81] California Civil Code § 56.05(f) provides that the "Medical information" covered by CMIA § 56.05(f) includes "any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care or health care service plan, or contractor regarding a patient's medical history, mental or physical condition, or treatment. 'Individually identifiable' means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity."

[82] *See* California Civil Code § 56.10(a), which provides that "[n]o provider of health care, health service plan, or contractor, shall disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization, except as provided in subdivision (b) or (c)." Subdivisions (b) and (c) discuss when medical information can be released without authorization from the client.

Evidentiary Privileges

The ethical duty to protect confidential client information applies to *all* professionals in *all* settings. In the courtroom, however, and in other legal settings,[83] some professionals have an obligation to protect confidential information that is *in addition* to the ethical obligation. In legal proceedings, the law reinforces the ethical duty with special rules called evidentiary privileges.[84] Privileges such as the psychotherapist-patient privilege and the physician-patient privilege add a layer of protection to the protection provided by the ethical duty to protect confidential information.

Whether communication between a client and a professional is privileged has little to do with the professional's ethical duty to protect confidential information. With this in mind, it is reasonable to ask, "In legal proceedings, what difference does it make whether a privilege applies? As a professional, I'm ethically obligated to protect confidential information. Isn't the ethical duty sufficient to prevent disclosure in court?" The answer is no. In legal proceedings, the existence of a privilege such as the psychotherapist-patient privilege can spell the difference between privacy and disclosure. The reason is that in court, professionals generally must answer questions that require disclosure of information they are ethically obligated to protect. In other words, when a professional is a witness in court, the duty to answer questions generally trumps the ethical duty to protect confidential information. If a privilege applies, however, a professional generally does *not* have to answer questions that require disclosure of privileged information. Thus, in legal proceedings, a privilege affords greater protection than the ethical duty to protect confidentiality.

What kinds of communications are covered by privilege?

The client's confidential verbal statements to the professional are covered, as are the professional's notes documenting a client's words. In addition, a professional's verbal statements *to* a client are covered by the privilege. Gestures that are communicative are covered. The privilege covers confidential written, telephone, and e-mail communication between a client and a professional.[85] For guidance on ethical and confidentiality issues raised by electronic communication, see the materials cited in the footnote.[86]

How long does a privilege last?

Generally, privileged communications remain privileged after termination of the professional relationship. Death of the client generally does not end a privilege.

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[83] "Other legal settings" includes depositions, interrogatories, administrative hearings, and legislative proceedings.

[84] Evidentiary privileges are also called testimonial privileges.

[85] *See* California Evidence Code § 1012, defining confidential communication between a patient and a psychotherapist as follows:

> As used in [the psychotherapist-patient privilege], "confidential communication between patient and psychotherapist" means information, including information obtained by an examination of the patient, transmitted between a patient and his psychotherapist in the course of that relationship and in confidence by a means which, so far as the patient is aware, discloses the information to no third persons other than those who are present to further the interest of the patient in the consultation, or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the psychotherapist is consulted, and includes a diagnosis made and the advice given by the psychotherapist in the course of that relationship.

[86] The expanding use in mental health of electronic communication raises a plethora of ethical and legal issues. For guidance *see* Keith Humphreys, Andrew Winzelberg & Elena Klaw. (2000). Psychologists' Ethical Responsibilities in Internet-Based Groups: Issues, Strategies, and a Call for Dialogue. *Professional Psychology: Research and Practice, 31,* 493–496; Gerald P. Koocher & Elisabeth Morray, Regulation of Telepsychology: A Survey of State Attorneys General. (2000). *Professional Psychology: Research and Practice, 31,* 503–508; Marlene M. Maheu and Barry L. Gordon. (2000). Counseling and Therapy on the Internet. *Professional Psychology: Research and practice, 31,* 484–489.

Whose privilege is it?

With two exceptions, privileges in California belong to the client, not the professional. The client is the "holder" of the privilege.[87] The first exception is the clergyman-penitent privilege, which belongs both to the penitent and the clergy member.[88] The second exception relates to children in Juvenile Court dependency proceedings. In dependency cases, the child's attorney is a holder, along with the child, of the child's privileges when the child lacks the maturity to exercise the privilege.[89]

The professional must assert the privilege on the client's behalf

Although the professional is not the holder of the privilege, the professional is ethically and legally[90] obligated to assert the privilege on the client's behalf at the appropriate juncture in legal proceedings.

Three requirements for privilege

Three requirements must be met for communications to be privileged. First, the communication must be between a client and a professional who is covered by a privilege. In California, the physician-patient privilege covers physicians, including psychiatrists.[91] The psychotherapist-patient privilege covers licensed psychologists,[92] licensed clinical social workers,[93] licensed marriage and family therapists,[94] school psychologists,[95] educational psychologists,[96] psychiatrists,[97] registered nurses who possess a Master's degree

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[87] California Evidence Code § 1013.

[88] *See* California Evidence Code § 1030 et. seq.

[89] California Welfare and Institutions Code § 317(f).

[90] The California Evidence Code requires professionals to assert privilege on behalf of their clients.

Psychotherapist-patient privilege. California Evidence Code § 1015 provides: "The psychotherapist who received or made a communication subject to the privilege under this article shall claim the privilege whenever he is present when the communication is sought to be disclosed and is authorized to claim the privilege under subdivision (c) of Section 1014." Section 1014(c) states that the psychotherapist-patient privilege may be claimed by "[t]he person who was the psychotherapist at the time of the confidential communication, but such person may not claim the privilege if there is no holder of the privilege in existence or if he or she is otherwise instructed by a person authorized to permit disclosure."

Physician-patient privilege. California Evidence Code § 995 provides: "The physician who received or made a communication subject to the privilege under this article shall claim the privilege whenever he is present when the communication is sought to be disclosed and is authorized to claim the privilege under subdivision (c) of Section 994." Section 994(c) states that the physician-patient privilege may be claimed by "[t]he person who was the physician at the time of the confidential communication, but such person may not claim the privilege if there is no holder of the privilege in existence or if he or she is otherwise instructed by a person authorized to permit disclosure."

Sexual assault victim-counselor privilege. *See* California Evidence Code §§ 1035.8(c) and 1036, containing language identical to the language regarding the physician-patient and the psychotherapist-patient privileges.

Domestic violence victim-counselor privilege. *See* California Evidence Code §§ 1037.5 and 1037.6, containing language identical to the language regarding the physician-patient and the psychotherapist-patient privileges.

[91] California Evidence Code § 990.

[92] California Evidence Code § 1010(b).

[93] California Evidence Code § 1010(c). The privilege applies when a clinical social worker "is engaged in applied psychotherapy of a nonmedical nature."

[94] California Evidence Code § 1010(e).

[95] California Evidence Code § 1010(d). The privilege applies when "[a] person who is serving as a school psychologist and holds a credential authorizing that service issued by the state."

[96] California Evidence Code § 1010.5.

[97] California Evidence Code § 1010(a). Section 1010(a) provides that the word psychotherapist includes "[a] person authorized, or reasonably believed by the patient to be authorized, to practice medicine in any state or nation who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry."

in psychiatric mental health nursing,[98] and various interns, assistants, and trainees.[99] The sexual assault victim-counselor privilege covers professionals providing rape crisis and victim/witness counseling.[100] The domestic violence victim-counselor privilege covers specified professionals providing counseling to victims of domestic violence.[101]

The second requirement for privilege is that the client must seek professional services. With a psychotherapist, for example, the client must consult the therapist to obtain professional advice, diagnosis, or treatment. If the client formally enters treatment, the privilege applies to confidential communications during therapy. Even when the client does not formally enter therapy, the privilege may apply to confidential communications between the client and the therapist who declines to treat the client, or who refers the client to a second professional.

The third requirement for privilege is that the communication must be in confidence. Privileges only cover communications that are intended to be confidential.[102] The unspoken assumption is that anything said during treatment is intended to be confidential. When a privilege is claimed on the basis of the psychotherapist-patient, physician-patient, or clergyman-penitent privileges, the law presumes the communication was confidential.[103]

What if someone else is present when a client says something to a professional? Does the presence of the third person destroy the confidentiality required for privilege? It depends. If the third person is present to assist the professional, privilege should attach. When the client is a child, presence of a parent need not defeat privilege.

A privilege is not destroyed when colleagues consult about cases. Nor is privilege eliminated when confidential information is discussed during clinical supervision.[104]

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98 California Evidence Code § 1010(k).

99 California Evidence Code § 1010(f) (registered psychological assistant working under supervision; marriage and family therapist intern working under supervision); § 1010(g) (associate social worker working under supervision); § 1010(h) (persons exempt from Psychology Licensing Law working under supervision); § 1010(i) (psychological intern working under supervision); § 1010(j) (trainee under Section 4980.03(c) of the California Business and Professions Code).

100 For the definition of "sexual assault victim-counselor," *see* California Evidence Code § 1035.2.

101 For the definition of "domestic violence counselor" *see* California Evidence Code § 1037.1.

102 California Evidence Code § 917 (Comment — Assembly Committee on Judiciary: "Of course, if the facts show that the communication was not intended to be kept in confidence, the communication is not privileged. And the fact the communication was made under circumstances where others could easily overhear is a strong indication that the communication was not intended to be confidential and is, therefore, unprivileged.").

103 California Evidence Code § 917. Under Section 917, "the opponent of the claim of privilege has the burden of proof to establish that the communication was not confidential."

104 *See* California Evidence Code § 912 (Comment — Senate Committee on Judiciary: "Nor would a physician's or psychotherapist's keeping of confidential records necessary to diagnose or treat a patient, such as confidential hospital records, be a waiver of the privilege, even though other authorized persons have access to the records.").

See also California Confidentiality of Medical Information Act, California Civil Code § 56.10(c)(1) (a professional may release confidential client information to other professionals "for purposes of diagnosis or treatment of the patient.").

See also S.G. Nye, Legal Issues in the Practice of Child Psychiatry. In D.H. Schetky & E.P. Benedek, *Child Psychiatry and the Law* (pp. 266–286) (1980), where Nye writes:

> A patient's confidential data may be shared without his/her consent within the clinic/agency or institution for purposes of the patient's treatment. It is generally accepted that supervisors and consultants are considered part of the patient's "treatment team." Any such professional with whom the information is shared will have the same duty to maintain confidentiality as the patient's own therapist.

Id. at 281–282.

See also William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed with Caution* p. 51 (1999) (Phoenix, AZ: Zeig, Tucker & Co.) ("Sharing information with one's supervisor is not a breach of privilege or confidentiality.").

The Psychotherapist-Patient Privilege

The psychotherapist-patient privilege applies to confidential communications between psychotherapists and patients who consult psychotherapists for diagnosis *or* treatment of mental or emotional conditions.[105] The privilege applies to children[106] and adults. The psychotherapist-patient privilege applies in all legal proceedings, civil and criminal.[107]

Under Evidence Code § 730, a judge may appoint an expert to examine or evaluate a child. The expert submits a report to the court, and may testify. Section 1017(a) of the Evidence Code provides that "There is no [psychotherapist-patient] privilege … if the psychotherapist is appointed by order of a court to examine the patient… ."

Physician-Patient Privilege

The physician-patient privilege applies to confidential communications between a physician and a patient seeking diagnosis or treatment of physical or mental conditions.[108] Unlike the psychotherapist-patient privilege, which applies in all legal proceedings, the physician-patient privilege applies only in civil proceedings. The physician-patient privilege does not apply in criminal litigation.[109]

Privilege in Group, Family, and Couples Therapy

The ethical duty to protect confidential information applies to professionals conducting group therapy. Members of the group, however, are not ethically bound to protect confidentiality.[110] Some therapists engage members of the group in discussion of the importance of confidentiality. Appelbaum and Greer state that "it seems clear that group leaders should alert their patients that the sanctity of their communications depends on the goodwill of their fellow patients."[111] The *Code of Ethics* of the National Association of Social Workers suggests that "[w]hen social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements."[112]

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[105] California Evidence Code § 1011. The privilege also applies to individuals who submit to psychological examination for purposes of scientific research. *See* San Diego Trolley v. Superior Court, 87 Cal. App. 4th 1083 (2001).

The term "confidential communication between patient and psychotherapist" is defined in California Evidence Code § 1012.

[106] *See* In re Daniel C.H., 220 Cal. App. 3d 814 (1990).

[107] California Evidence Code § 1014 (Comment — Senate Committee on Judiciary: "Although the psychotherapist-patient privilege applies in a criminal proceeding, the privilege is not available to a defendant who puts his mental or emotional condition in issue, as, for example, by a plea of insanity … .").

[108] California Evidence Code § 992. The physician-patient privilege applies not only to words exchanged between the patient and the doctor, but also to what the doctor sees when examining the patient.

The privilege applies when the patient seeks diagnostic services only, without treatment. *See* California Evidence Code § 991 (Comment: Senate Committee on Judiciary: "Patient" means a person who consults a physician for the purpose of diagnosis *or* treatment.") (emphasis in original).

[109] California Evidence Code § 998.

[110] *See* American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 5.01(a) provides: "Psychologists discuss with persons and organizations with whom they establish a scientific or professional relationship (including, to the extent feasible, minors and their legal representatives) (1) the relevant limitations on confidentiality, including limitations where applicable in group, marital, and family therapy or in organizational consulting, and (2) the foreseeable uses of the information generated through their services.").

[111] P.S. Appelbaum & A. Greer, Confidentiality in Group Therapy, 44 *Law and Psychiatry* 311–312, at 312 (1993).

[112] National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.07(f)).

In addition to the ethical duty to protect confidential client information, the psychotherapist-patient privilege can apply in group, family, and couples therapy.[113]

Confidentiality When the Client is a Child

Difficulties arise when the client is a child. The ethical obligation to protect confidentiality applies regardless of age, and confidential information cannot be revealed to outsiders unless consent is obtained or disclosure is required by law. But are parents "outsiders"? May professionals discuss confidential information with parents without a child's permission? An example illustrates why there are no simple, across-the-board answers to this question. Suppose a professional's clients are 5 and 15 years of age. In the preschooler's case, it seems clear that the parents will be consulted regularly. The child may be informed that the therapist talks to mommy and daddy, but it would be developmentally inappropriate and legally unnecessary to seek the child's "consent" to disclose information to the parents. By contrast, it is developmentally appropriate, and perhaps legally necessary, to safeguard the teenager's confidential revelations from parents.

The 5 and 15-year-olds are easy. But what about a 9 or 10-year-old client? Where does such a child fit along the continuum of confidentiality? There is no simple, one-size-fits-all answer. Much depends on the maturity and mental stability of the child, the reasons for treatment, and the nature of the relationship between the parents and the child.

Regardless of age, a professional's first duty is to the child. This is so regardless of who pays for treatment. Thus, the fact that a child's parents pay for therapy does not entitle the parents to confidential information.[114] A useful way to deal with potential conflicts over confidential information is to set ground rules *before* therapy begins.[115] When the child is developmentally capable of participating in this process, the child's input should be obtained.[116] Berner advises that "[w]hile it is not always clear what privacy rights children actually enjoy under the law, good clinical practice requires that you work out some rules or guidelines which protect the child's confidences and the integrity of the therapy, while allowing the parents to remain appropriately involved."[117] Brant and Brant add that "[t]herapists should attempt to negotiate these 'confidentiality boundaries" between parent and child at the beginning of treatment as part of the treatment contract. Arrangements will vary with the age of the child, with adolescents usually requesting and requiring

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[113] *See* Lovett v. Superior Court, 203 Cal. App. 3d 521 (1988).

[114] *See* In re Daniel C.H., 220 Cal. App. 3d 814 (1990).

[115] *See* Stephen H. Behnke, James Preis & R. Todd Bates, *The Essentials of California Mental Health Law: A Straightforward Guide for Clinicians of All Disciplines* 188–189 (1998) (New York: W.W. Norton), where the authors write:

> If a parent insists that you discuss the treatment, or that you provide your records for review, and you believe that such disclosures are clinically *contra*indicated, reply that you are not able to do so and explain why. A statement that the treatment's success depends on keeping certain information within the bounds of the therapy will suffice. Given the strong presumption in favor of involving a parent or guardian in the treatment, a mental health professional should always document her decision-making process when she decides not to disclose client material to a parent or guardian. The parent or guardian is then free to ask a court to order that your records be made available; at that point, you would have an opportunity to tell a judge your reasons for not sharing the information. The judge will decide what should happen.

[116] *See* William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed With Caution* pp. 92–93 (1999) (Phoenix, AZ: Zeig, Tucker & Co.) ("It is wise to discuss limitations on confidentiality with both parents and the young patient at the beginning of treatment. You may have policies about informally keeping a child's confidences, with a broadly understood intent to keep his or her comments private; however, do not promise that 'everything you say will be confidential.' When the child's safety or other important interests are at stake, bring the parents into the picture.").

[117] Marilyn Berner, Write Smarter, Not Longer, in Lawrence E. Lifson & Robert I. Simon (Eds.), *The Mental Health Practitioner and the Law: A Comprehensive Handbook* pp. 61–71, at 65 (1998) (Cambridge, MA: Harvard University Press).

more explicit contracts around confidentiality. The therapist must address the question of access to records at the commencement of treatment."[118]

If a parent abused or neglected a child, disclosure of the child's confidential information to the maltreating parent may be contraindicated regardless of the child's age.[119]

Confidentiality of Progress Reports on Children in Court-Ordered Treatment

When a judge orders therapy for a child, the typical procedure is for a social worker to make the treatment referral. The judge and the social worker expect periodic reports from the child's therapist. Yet, information obtained from the child during court-ordered treatment is confidential, and may be privileged. On the one hand, the therapist wants to cooperate with the court and social services, both of which are endeavoring to help the child. On the other hand, the therapist is obliged to protect confidentiality. Is there an escape from this dilemma? With a little planning and good will, the answer can be yes. When possible, resolve the issue before therapy begins. In many cases the judge can be asked to specify in the court order that the therapist will provide periodic progress reports. Place a copy of the court order in the child's clinical file. Unless contraindicated, inform the child's parents of the court order, and obtain their written consent. Progress reports generally do not have to reveal all that goes on during therapy. In many cases a report can keep the court informed without disclosing sensitive information. Finally, the therapist may ask that progress reports that become part of the court record be shielded from inappropriate disclosure.

Disclosure of Confidential and Privileged Information

Professionals are encouraged to discuss release of confidential information early in the professional relationship.[120] When confidential information is disclosed, release only so much information as is required under the circumstances.[121] The *Code of Ethics* of the National Association of Social Workers provides that "[i]n all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is relevant to the purpose for which the disclosure is made should be revealed."[122] The following subsections discuss disclosure of confidential and privileged client information.

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[118] Renee Tankenoff Brant & Jonathan Brant, Child and Adolescent Therapy, in Lawrence E. Lifson & Robert I. Smith (Eds.), *The Mental Health Practitioner and the Law: A Comprehensive Handbook* pp. 73–88, at 76 (1998) (Cambridge, MA: Harvard University Press).

[119] *See* In re Daniel C.H., 220 Cal. App. 3d 814 (1990).

[120] *See* James Hilliard, Liability Issues with Managed Care, in Lawrence E. Lifson & Robert I. Simon (Eds.), *The Mental Health Practitioner and the Law: A Comprehensive Handbook* pp. 50–53, at 51 (1998) (Cambridge, MA: Harvard University Press) ("Providers should discuss the issue of access to records with their patients at the early stages of treatment to avoid problems later and to determine early on the process of records access by the managed care company.").

[121] *See* Stephen H. Behnke, James Preis & R. Todd Bates, *The Essentials of California Mental Health Law: A Straightforward Guide for Clinicians of All Disciplines* (1998) (New York: W. W. Norton). *See also* San Diego Trolley v. Superior Court, 87 Cal. App. 4th 1083 (2001).

[122] National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.07(c)).

Client Consent

The client may consent to release of confidential and privileged information.[123] Release without necessary client consent can be malpractice.[124] Client consent is discussed below in the context of the California Confidentiality of Medical Information Act.

Child Abuse Reporting Law Overrides Privilege and Confidentiality

California's child abuse reporting law overrides privilege and the ethical duty to maintain confidentiality.[125] When complying with the reporting law, however, disclose only as much confidential information as is needed to comply with the reporting obligation. Information that is not needed for the report remains confidential.[126] Kalichman writes:

> Once the information that is needed to report is collected or organized, the next step is to contact the social service agency responsible for taking reports. There are, however, additional ethical considerations to make when determining what to include in a report. The level of detail released in a report should be limited to an amount that minimizes breaches of confidentiality while maximizing child protection. It is not necessary to release information in a report unless it will assist the social service agency in making determinations of abuse or will help the agency to take action on behalf of the child and family. As stated in the *Ethical Principles of Psychologists and Code of Conduct*, "In order to minimize intrusions on privacy, psychologists include in written and oral reports, consultations, and the like, only information germane to the purpose for which the communication is made." (Standard 5.03a). In reporting suspected child abuse, the purpose of the information released is to protect children. Information should therefore be limited to the degree to which child protection will be achieved.[127]
>
> Professionals should be aware that including more information than is necessary in a mandated report, and providing additional information after a report is filed, can violate privacy rights and can raise issues of liability. Circumstances unrelated to the suspicion of abuse, such as details of family life and family relationships that are peripheral to the abuse, need not be included in a report.[128]

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[123] *See* National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.07(b): "Social workers may disclose confidential information when appropriate with valid consent from the client or a person legally authorized to consent on behalf of a client."); American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 5.05(b): "Psychologists may also disclose confidential information with the appropriate consent of the patient or the individual or organizational client (or of another legally authorized person on behalf of the patient or client), unless prohibited by law."); American Medical Association, *The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry* (1998) (Section 4, ¶ 2: "A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion.").

[124] *See* Fierstein v. DePaul Health Center, 24 S.W.3d 220 (Mo. Ct. App. 2000).

[125] *See* California Evidence Code § 1037.3 (domestic violence victim-counselor privilege: "Nothing in this article shall be construed to limit any obligation to report instances of child abuse as required by Section 11166 of the Penal Code.").

[126] *See* American Medical Association, *The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry* (1998) (Section 4, ¶ 5: "Ethically the psychiatrist may disclose only that information which is relevant to the given situation").

[127] Seth C. Kalichman, *Mandated Reporting of Suspected Child Abuse: Ethics, Law, & Policy* p. 148 (2nd ed. 1999) (Washington, D.C.: American Psychological Association).

[128] *Id.* at 149.

Reviewing Client Records Prior to Testifying

When a professional prepares to testify, it is often necessary to review the client's record. Some professionals take records to court. Although reviewing records is usually necessary and proper, a word of caution is in order. Information in a client's record is confidential, and may be privileged. Yet, if the professional reviews the record prior to testifying, or refers to the record while on the witness stand, the opposing attorney may have the right to inspect the record and ask questions about it.[129] Thus, the contents of the client's record could be revealed to everyone in the courtroom, including the person accused of child abuse.

Emergencies

In genuine emergencies, essential information may be released without consent.

Psychotherapist Appointed by Court to Examine Patient

The psychotherapist-patient privilege does not attach when a psychotherapist is appointed by order of a judge to examine a patient.[130] Privilege may attach, however, when a psychotherapist is court-appointed to provide treatment.[131]

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[129] California Evidence Code § 771 provides:

> (a) Subject to subdivision (c), if a witness, either while testifying or prior thereto, uses a writing to refresh his memory with respect to any matter about which he testifies, such writing must be produced at the hearing at the request of an adverse party and, unless the writing is so produced, the testimony of the witness concerning such matter shall be stricken.
>
> (b) If the writing is produced at the hearing, the adverse party may, if he chooses, inspect the writing, cross-examine the witness concerning it, and introduce in evidence such portion of it as may be pertinent to the testimony of the witness.
>
> (c) Production of the writing is excused, and the testimony of the witness shall not be stricken, if the writing:
>
> (1) Is not in the possession or control of the witness or the party who produced his testimony concerning the matter; and
>
> (2) Was not reasonably procurable by such party through the use of the court's process or other available means.

[130] California Evidence Code § 1017 provides:

> (a) There is no privilege under this article if the psychotherapist is appointed by order of a court to examine the patient, but this exception does not apply where the psychotherapist is appointed by order of the court upon the request of the lawyer for the defendant in a criminal proceeding in order to provide the lawyer with information needed so that he or she may advise the defendant whether to enter or withdraw a plea based on insanity or to present a defense based on his or her mental or emotional condition.
>
> (b) There is no privilege under this article if the psychotherapist is appointed by the Board of Prison Terms to examine a patient pursuant to the provisions of Article 4 (commencing with Section 2960) of Chapter 7 of Title 1 of Part 3 of the Penal Code.

The Law Revision Commission Comment on Section 1017 states that "[g]enerally, where the relationship of psychotherapist and patient is created by court order, there is not a sufficiently confidential relationship to warrant extending the privilege to communications made in the course of that relationship. Moreover, when the psychotherapist is appointed by the court, it is most often for the purpose of having the psychotherapist testify concerning his conclusions as to the patient's condition."

[131] *See* In re Eduardo A., 209 Cal. App. 3d 1038, 1041 (1989) ("We do not consider a juvenile court referral for counseling to be the equivalent of a court-ordered examination of a patient by a psychotherapist within the meaning of Evidence Code section 1017, subdivision (a)."). *See also* In re Pedro M., 81 Cal. App. 4th 550 (2000) (delinquency case; it was not error for a delinquent's therapist to testify in limited form in juvenile court despite minor's assertion of psychotherapist-patient privilege).

Victim Under Age 16

The psychotherapist-patient privilege does not prohibit disclosure in court when (1) the client is under the age of sixteen, (2) the psychotherapist believes that the child has been the victim of a crime such as child abuse, and (3) disclosure of privileged information is in the child's best interest.[132]

Tarasoff — The Dangerous Patient Exception to Confidentiality[133]

In 1976, the California Supreme Court ruled in the famous *Tarasoff* case that a psychotherapist has a legal duty to warn the potential victim of a client who threatens the victim.[134] In *Tarasoff*, a disturbed young man murdered the woman he professed to love. The parents of the murdered woman sued the murderer's therapist, alleging that the therapist knew his client posed a danger to their daughter, but did not take sufficient steps to warn the victim or her parents. The Supreme Court ruled that "when a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger."[135] In a later decision, the California Court of Appeal ruled that the duty to warn does not extend to the general public. The duty arises only when a patient threatens a readily identifiable victim.[136] The California Civil Code further clarifies the duty to warn. The Code states that a psychotherapist's duty to warn arises only "where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims."[137] The Civil Code continues that "[i]f there is a duty to warn and protect …, the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency."[138]

A *Tarasoff*-style duty to warn can arise when a psychotherapist learns that a client plans to sexually abuse a particular child.[139] Moreover, a duty to warn might exist in a case in which no particular child is targeted, but in which a sexually dangerous client has access to readily identifiable children.[140]

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[132] California Evidence Code § 1027. The Law Revision Commission Comment to Section 1027 provides:

> The exception provided in Section 1027 is necessary to permit court disclosure of communications to a psychotherapist by a child who has been the victim of a crime (such as child abuse) in a proceeding in which the commission of such crime is a subject of inquiry. Although the exception provided by Section 1027 might inhibit the relationship between the patient and his psychotherapist to a limited extent, it is essential that appropriate action be taken if the psychotherapist becomes convinced during the course of treatment that the patient is the victim of a crime and that disclosure of the communication would be in the best interest of the child.

[133] California Evidence Code § 1024 provides that "[t]here is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger." See San Diego Trolley v. Superior Court, 87 Cal. App. 4th 1083 (2001).

[134] Tarasoff v. Regents of the University of California, 17 Cal. 3d 425 (1976).

See National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.07(c) provides in part: "Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to the client or other identifiable person.").

[135] Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 431 (1976).

[136] Thompson v. County of Alameda, 88 Cal. App. 3d 936 (1979).

[137] California Civil Code § 43.92(b).

[138] California Civil Code § 43.92(b).

[139] Bradley v. Ray, 904 S.W.2d 302 (Missouri Ct. App. 1995).

[140] *See* Barry v. Truek, 218 Cal. App. 3d 1241 (1990) (Adult woman asserted that she was part of a group of reasonably identifiable victims of a psychotherapist's patient, who had a history of sexual assault).

Patient-Litigant Exception to Privilege

A privilege does not apply when a client involved in litigation deliberately makes an issue of the client's physical or mental condition, and when privileged information relates to that condition.[141] Suppose, for example, that a child receiving psychotherapy for the effects of sexual abuse sues the person who abused her. In the lawsuit, the child's attorney claims that the child's mental suffering is a direct result of the abuse. The lawsuit seeks money from the perpetrator to compensate the child for mental suffering. The perpetrator's attorney, however, argues that the perpetrator is not responsible for the child's mental condition because, according to the perpetrator, the child's condition preexisted the abuse. In this situation, the patient-litigant exception to the psychotherapist-client privilege may apply, allowing portions of what went on during psychotherapy to be disclosed.

The Crime-Tort Exception to Privilege

There is no privilege if the services of a professional are sought to enable anyone to commit a crime or a tort, or to escape detection by the police.[142]

A Criminal Defendant's Constitutional Right to Confidential Records

In criminal cases, the defendant has a limited constitutional right to inspect confidential records on the victim.

The California Confidentiality of Medical Information Act (CMIA)

In California, CMIA plays a central role in the release of client records.[143] CMIA applies to mental health and medical records.[144] In *Person v. Farmers Insurance*,[145] the California Court of Appeal ruled that the contents of a client's record belong to the client, not the professional.[146] Under CMIA, professionals may not disclose information regarding clients without proper authorization.[147]

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[141] California Evidence Code § 996 (physician-patient privilege); § 1016 (psychotherapist-patient privilege).

[142] California Evidence Code § 997 (physician-patient privilege); § 1018 (psychotherapist-patient privilege).

[143] The Confidentiality of Medical Information Act is located at California Civil Code § 56 et. seq.

[144] CMIA § 56.05(f) defines "Medical information" as "any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care or health care service plan, or contractor regarding a patient's medical history, mental or physical condition, or treatment." CMIA § 56.05(h) defines "Provider of health care" to include the full range of mental health professionals.

[145] 52 Cal. App. 4th 813 (1997).

[146] *See* Stephen H. Behnke, James Preis & R. Todd Bates, *The Essentials of California Mental Health Law: A Straightforward Guide for Clinicians of All Disciplines* p. 145 (1998) (New York: W. W. Norton). The authors ask, "Who owns a therapist's records?" Responding to their own question, the authors write that "[t]he best way to answer this question is to think of the patient as owning the *contents* of the record and the therapist as owning the *physical document*."

[147] CMIA § 56.10(a).

Required Disclosure under CMIA:

A professional is *required* to disclose client information if the request for disclosure comes from the following:

1. Competent adult client.[148]
   A competent adult client may consent to release of information to attorneys, courts, the client her or himself,[149] and anyone else selected by the client.[150] Consent should be in writing, signed by the client.[151] The client's consent should be voluntary and informed. The professional may wish to inform the client of advantages and disadvantages of disclosure. For example, the client should know that release of privileged information could waive the psychotherapist-patient privilege.[152] A privilege is waived when the holder of the privilege voluntarily discloses a significant part of a privileged communication.[153] Once consent is given, the client may withdraw permission to disclose records.[154]

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[148] CMIA § 56.28 provides that "[n]othing in [CMIA] shall be deemed to affect existing laws relating to a patient's right of access to his or own medical information, or relating to disclosures made pursuant to Section 1158 of the Evidence Code, or relating to privileges under the Evidence Code."

[149] *See* Stephen H. Behnke, James Preis & R. Todd Bates, *The Essentials of California Mental Health Law: A Straightforward Guide for Clinicians of All Disciplines* p. 146 (1998) (New York: W.W. Norton) ("For both clinical and risk management reasons, you should insist that you and your client review the record together. From a clinical perspective, the patient may encounter material that is unclear or troubling, and your presence will be important to address questions or concerns. From a risk management perspective, clients sometimes walk away with the record tucked under their arm. You are then deprived of your most important defense should the client make a claim against you. *A client should never be left alone with the original record.*").

See also National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.08 provides: "(a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files. (b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.").

[150] CMIA § 56.10(b)(7).

See American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 5.05(b): "Psychologists also may disclose confidential information with the appropriate consent of the patient or the individual or organizational client (or of another legally authorized person on behalf of the patient or client), unless prohibited by law.").

[151] CMIA § 56.11 requires written consent.

See also Thomas G. Gutheil & Paul S. Appelbaum, *Clinical Handbook of Psychiatry and the Law* (1982) (New York: McGraw Hill), where the authors write that "[w]ritten consent is advisable for at least two reasons: (1) it makes clear to both parties that consent has, in fact, been given; (2) if the fact, nature or timing of the consent should ever be challenged, a documentary record exists. The consent should be made a part of the patient's permanent chart." *Id.* at 6.

[152] *See* American Medical Association, *The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry* (1998) (Section 4, ¶ 2: "A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy.").

[153] California Evidence Code § 912.

[154] CMIA § 56.15 ("Nothing in this part shall be construed to prevent a person who could sign the authorization pursuant to subdivision (c) of Section 56.11 from canceling or modifying an authorization.").

2. When the client is a child

When the client is a minor, parents usually have authority to consent to release of information.[155] In circumstances where a minor has legal authority to consent to care, however, the minor has legal authority to consent to disclosure of information.[156] A leading treatise of California family law states:

> The issue of who has the authority to consent to medical treatment of the minor also determines who has the right to inspect the minor's health care records. The right to inspect health care records in the possession of the hospital, physician, or other health care provider includes a right to copies of any or all of those records. A minor who has the authority to consent to his or her own medical treatment is

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[155] CMIA § 56.11(c)(2).

See California Family Code § 3025, which provides: "Notwithstanding any other provision of law, records and information pertaining to a minor, including, but not limited to, medical, dental, and other records, shall not be denied to a parent because the parent is not the child's custodial parent."

Despite the broad language of Section 3025, Kathryn Kirkland, Ira H. Lurvey & Diana Richmond write in *California Family Law Practice and Procedure* (2nd ed. 1998) (San Francisco: Matthew Bender):

> Notwithstanding these statutory provisions and any other provision of law, access to a child's medical and dental records may not be denied to a parent because that parent is not the child's custodial parent. However, Family Code Section 3025 does not establish an absolute right of noncustodial parental [sic] to access to such records; that is, it does not necessarily override other legal principles or privileges that may preclude parental access to such records. Thus, for example, a parent may be denied access to the records and testimony of a child's psychotherapist, based on the psychotherapist-patient privilege, if disclosure will harm the therapeutic relationship or have a detrimental effect on the child.

Id. vol. 2, ¶ 30.35[1], p. 30-30.

[156] For circumstances in which a child has authority to consent to mental health and medical care, *see* the discussion in the section Informed Consent By Children.

See Stephen H. Behnke, James Preis & R. Todd Bates, *The Essentials of California Mental Health Law: A Straightforward Guide for Clinicians of All Disciplines* p. 148 (1998) (New York: W. W. Norton) ("When your client is a minor, she is entitled access only to those records that concern health care for which she is authorized to consent. When a minor has the right to see treatment records, her parents or guardian do not.").

See also CMIA § 56.11, which provides:

> An authorization for the release of medical information by a provider of health care, a health care service plan, or contractor shall be valid if it:
>
> (a) Is handwritten by the person who signs it or is in typeface no smaller than 8-point type.
>
> (b) Is clearly separate from any other language present on the same page and is executed by a signature which serves no other purpose than to execute the authorization.
>
> (c) Is signed and dated by one of the following:
>
> (1) The patient. A patient who is a minor may only sign an authorization for the release of medical information obtained by a provider of health care, health service plan, or contractor in the course of furnishing services to which the minor could lawfully have consented under [law].
>
> (2) The legal representative of the patient, if the patient is a minor or an incompetent. However, authorization may not be given under this subdivision for the disclosure of medical information obtained by the provider of health care, a health care service plan, or a contractor in the course of furnishing services to which a minor patient could lawfully have consented under [law].
>
> (3) The spouse of the patient … .
>
> (4) The beneficiary or personal representative of a deceased patient.
>
> (d) States the specific uses and limitations on the types of medical information to be disclosed.
>
> (e) States the name or functions of the provider of health care, health care service plan, or contractor that may disclose the medical information.

entitled to inspect his or her records pertaining only to the type of health care to which he or she is authorized to consent.[157]

3. Court order
   A professional must disclose client information if a judge orders disclosure.[158] For these purposes, a subpoena is not a court order. For children involved with the Juvenile Court, several individuals (*e.g.*, social workers, relatives, parents, attorneys) may seek access to the child's treatment record. If doubts arise about the propriety of access, the best practice may be to deny access and tell the person to seek an order from Juvenile Court authorizing access.

4. Subpoena
   A professional must disclose client information in response to a valid subpoena. Not all subpoenas are valid, however. If there are questions about a subpoena, consult an attorney *before* responding to the subpoena. (*See* discussion of subpoenas later in this chapter).

5. Boards, commissions, administrative agencies
   Certain boards, commissions, administrative agencies, and arbitrators can compel disclosure of client information.[159]

6. Search warrant
   A professional must disclose client information in response to a lawful search warrant.[160]

(f) States the name or functions of the persons or entities authorized to receive the medical information.

(g) States the specific uses and limitations on the use of the medical information by the persons or entities authorized to received the medical information.

(h) States the specific date after which the provider of health care, health care service plan, or contractor is no longer authorized to disclose the medical information.

(i) Advises the person signing the authorization of the right to receive a copy of the authorization.

[157] Kathryn Kirkland, Ira H. Lurvey & Diana Richmond, *California Family Law Practice and Procedure* vol. 2, § 30.34[6], pp. 30-29 to 30-30 (2nd 1998) (San Francisco: Matthew Bender).

[158] CMIA § 56.10(b)(1).

[159] CMIA § 56.10(b)(2); (b)(4); (b)(5).

[160] CMIA § 56.10(b)(6).

Discretionary Disclosure Under CMIA:

In addition to circumstances where professionals are *required* to disclose client records, CMIA gives professionals discretion to disclose client records in several situations,[161] including the following:

1. Consultation and Supervision

   Client information may be shared with colleagues for purposes of supervision and consultation.[162] The American Psychological Association's *Code of Conduct* provides, however, that "[i]n order to minimize intrusions on privacy, psychologists include in written and oral reports, consultations, and the like, only information germane to the purpose for which the communication is made."[163] The National Association of Social Worker's *Code of Ethics* provides that "[s]ocial workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure."[164] Although the client does not have to consent to consultation,[165] it is a good idea, at the outset of therapy, to inform the client that consultation may be obtained, and to obtain permission.

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[161] For the full range of circumstances in which professionals may release client records, *see* CMIA § 56.10(c).

[162] CMIA § 56.10(c)(1)("The information may be disclosed to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient.").

See American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 1.20: "Psychologists arrange for appropriate consultations and referrals based principally on the best interests of their patients or clients, with appropriate consent, and subject to other relevant considerations, including applicable law and contractual obligations.").

See also William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed with Caution* p. 51 (1999) (Phoenix, AZ: Zeig, Tucker & Co.) ("The supervisor should discuss supervision rules and contingency plans for problems in advance, and the patient should be made generally (but not obsessively) aware that a highly trustworthy and qualified third person will have access to clinical information. … Sharing information with one's supervisor is not a breach of privilege or confidentiality").

[163] American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 5.03(a)). Standard 5.06 of the *Code* provides:

> When consulting with colleagues, (1) psychologists do not share confidential information that reasonably could lead to the identification of a patient, client, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they share information only to the extent necessary to achieve the purposes of the consultation.

[164] National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.07(q)).

See also James Hilliard, Liability Issues with Managed Care, in Lawrence E. Lifson & Robert I. Simon (Eds.), *The Mental Health Practitioner and the Law: A Comprehensive Handbook* pp. 50–53, at 53 (1998) (Cambridge, MA: Harvard University Press) ("Often a consultation on a difficult issue is in keeping with the standard of care. Therapists do not have to reveal the identity of their patient in order to seek a consultation. Under these circumstances, no breach of confidentiality occurs. When it is necessary to reveal the identity of a patient for a consultation, the patient's permission is necessary. A note in the patient's chart that permission was granted is usually sufficient. In all cases, whether the patient's identity is or is not revealed, a note of the consultation should be made.").

[165] *See* American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 5.05(a): "Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose, such as (1) to provide needed professional services to the patient or the individual or organizational client, (2) to obtain appropriate professional consultations, (3) to protect the patient or client or others from harm, or (4) to obtain payment for services, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.").

In his book on legal issues in psychotherapy, Reid makes the following sensible observation:

> From the treater's or evaluator's point of view, when important doubts about assessment or care arise, there are almost always ways to reduce them, and one of the best is to get advice from a peer or subspecialist. You do not need the patient's permission to do this. I cringe when I hear a psychiatrist or psychotherapist try to convince a jury that he or she couldn't ask for a second opinion about a patient's suicidal behavior because of "confidentiality." No state, so far as I know, limits clinical consultation intended in the patient's interest.[166]

2. Insurers

To the extent necessary to secure payment, client information may be released to insurers and other third party payers.[167] The professional should release only so much information as is necessary for payment.[168] Sensitive therapy notes usually are not necessary for this purpose, and should not be revealed.

When an entity like an insurance company requests client information specifically related to participation in outpatient treatment with a psychotherapist, the requesting entity must submit a written request to the client and the psychotherapist.[169]

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[166] William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed with Caution* p. 53 (1999) (Phoenix, AZ: Zeig, Tucker & Co.).

[167] CMIA § 56.10(c)(2) ("The information may be disclosed to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, contractor, or any other person or entity responsible for paying for health care services to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made.").

See National Association of Social Workers, *Code of Ethics* (1999) (Standard 1.07(h) provides: "Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.").

[168] *See* Renee Tankenoff Brant & Jonathan Brant, Child and Adolescent Therapy, in Lawrence E. Lifson & Robert I. Smith (Eds.), *The Mental Health Practitioner and the Law: A Comprehensive Handbook* pp. 73–88, at 76 (1998) (Cambridge, MA: Harvard University Press) ("Here too it is very important to obtain appropriate consent for release of information to insurance companies and to limit the information shared to that which is absolutely necessary."); Stephen H. Behnke, James Preis & R. Todd Bates, *The Essentials of California Mental Health Law: A Straightforward Guide for Clinicians of All Disciplines* p. 38 (1998) (New York: W. W. Norton) ("Because payment requires patient information, an exception to confidentiality is warranted. Note, however, that a mental health professional should never release information to a third party payor over a patient's explicit objection; a patient retains the prerogative to pay out of pocket or to stop treatment.").

[169] CMIA § 56.104 provides:

> (a) Notwithstanding subdivision (c) of Section 56.10, no provider of health care, health care service plan, or contractor may release medical information to persons or entities authorized by law to receive that information pursuant to subdivision (c) of Section 56.10, if the requested information specifically relates to the patient's participation in outpatient treatment with a psychotherapist, unless the person or entity requesting that information submits to the patient pursuant to subdivision (b) and to the provider of health care, health care service plan, or contractor a written request, signed by the person requesting the information or an authorized agent of the entity requesting the information, that includes all of the following:
>
> (1) The specific information relating to a patient's participation in outpatient treatment with a psychotherapist being requested and its specific intended use or uses.
>
> (2) The length of time during which the information will be kept before being destroyed or disposed of. [material on extending the time is deleted].
>
> (3) A statement that the information will not be used for any purpose other than its intended use.
>
> (4) A statement that the person or entity requesting the information will destroy the information [within the time specified in subdivision (2)].

Client Inspection and Copying of Records

With limited exceptions,[170] clients have a right to inspect and copy their records.[171] A mental health professional may deny inspection if there is a substantial risk that seeing the record will have significant detrimental consequences for the client.[172] When the client is a child, the parents normally have the right

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(b) The person or entity requesting the information shall submit a copy of the written request required by this section within 30 days of receipt of the information requested, unless the patient has signed a written waiver in the form of a letter signed and submitted by the patient to the provider of health care or health care service plan waiving notification.

[170] *See* California Health & Safety Code § 123125. Federal law relating to drug and alcohol treatment may supersede California law.

California Health & Safety Code § 123130 allows a professional to prepare a summary of a client's record. The client may inspect and copy the summary rather than the original records.

Records maintained by state agencies are governed by the California Information Practices Act, which prevails over the provisions of the Health and Safety Code. See California Health & Safety Code § 123140.

[171] *See* California Health & Safety Code § 12300 ("The Legislature finds and declares that every person having ultimate responsibility for decisions respecting his or her own health care also possesses a concomitant right of access to complete information respecting his or her condition and care provided. Similarly, persons having responsibility for decisions respecting the health care of others should, in general, have access to information on the patient's condition and care.").

See also California Health & Safety Code § 123105(b), which defines mental health records as "patient records, or discrete portions thereof, specifically relating to evaluation or treatment of a mental disorder. 'Mental health records' includes, but is not limited to, all alcohol and drug abuse records." Patient records "does not include information given in confidence to a health care provider by a person other than another health care provider or the patient, and that material may be removed from any records prior to inspection and copying under Section 123110 or 123115." *Id*. at § 123105(d).

See also California Evidence Code § 1158, allowing a client or the client's attorney to inspect and copy the client's file.

[172] California Health & Safety Code § 123115(b) provides:

> When a health care provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient, the provider may decline to permit inspection or provide copies of the records to the patient, subject to the following conditions:
>
> (1) The health care provider shall make a written record, to be included with the mental health records requested, noting the date of the request and explaining the health care provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted.
>
> (2) The health care provider shall permit inspection by, or provide copies of the mental health records to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, or licensed clinical social worker designated by request of the patient. Any marriage and family therapist registered intern, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, may not inspect the patient's mental health records or obtain copies thereof, except pursuant to the direction or supervision of a licensed professional specified in subdivision (f) of Section 4980.40 of the Business and Professions Code. Prior to providing copies of mental health records to a marriage and family therapist registered intern, a receipt for those records shall be signed by the supervising licensed professional. The licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or marriage and family therapist registered intern to whom the records are provided for inspection or copying shall not permit inspection or copying by the patient.
>
> (3) The health care provider shall inform the patient of the provider's refusal to permit him or her to inspect or obtain copies of the requested records, and inform the patient of the right to require the provider to permit inspection by, or provide copies to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, or licensed clinical social worker designated by written authorization of the patient.
>
> (4) The health care provider shall indicate in the mental health records of the patient whether the request was made under paragraph (2).

See also National Association of Social Workers, *Code of Ethics* (1999). Standard 1.08 provides:

> (a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm

to inspect and copy the child's records.[173] Parents may be denied access to their child's records when a mental health professional determines that parental access would be detrimental to the professional's relationship with the child, or when parental access would jeopardize the child's physical safety or psychological well being.[174] When a minor is legally authorized to consent to care, the minor has the right to inspect the minor's records.[175] Willful violation of a client's right to inspect and copy records is unprofessional conduct.[176]

Release of Information Regarding Persons Other than the Child

When children are in treatment, therapists sometimes include adults in aspects of therapy. For example, if the child is in foster care, the therapist may meet with the foster parents and offer advice on the child's care. The same is true when the child is living with grandparents or other relatives. Therapists should understand that involving adults in the therapeutic process can, in some circumstances, create a therapist-client relationship with the adults. Creation of such a relationship is not necessarily undesirable. From a legal perspective, however, creation of any therapist-client relationship means the therapist needs consent to release confidential information on the client. Whether or not a therapist-client relationship is created, it is good practice to think carefully before releasing information about adults involved in the child's care. Certainly, a therapist would think twice before expressing an opinion about an adult unless the therapist first evaluated the adult, and secured the adult's consent. To avoid creating a therapist-client relationship with adults, therapists can discuss the issue before involving adults in the child's therapy. It may be advisable to ask the adults to indicate their understanding in writing.

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to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files.

(b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

[173] California Health & Safety Code §§ 123100; 123105(e).

[174] California Health & Safety Code § 123115 provides:

(a) The representative of a minor shall not be entitled to inspect or obtain copies of the minor's patient records in either of the following circumstances:

(1) With respect to which the minor has a right of inspection under Section 123110.

(2) Where the health care provider determines that access to the patient records requested by the representative [parent] would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well being. The decision of the health care provider as to whether or not a minor's records are available for inspection under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith.

[175] California Health & Safety Code § 123110 provides in part:

(a) Notwithstanding Section 5328 of the Welfare and Institutions Code, and except as provided in Sections 125115 and 123120, any adult patient of a health care provider, any minor authorized by law to consent to medical treatment, and any patient representative shall be entitled to inspect patient records upon presenting to the health care provider a written request for those records and upon payment of reasonable clerical costs incurred in locating and making the records available. However, a patient who is a minor shall be entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. A health care provider shall permit this inspection during business hours within five working days after receipt of the written request. The inspection shall be conducted by the patient or patient's representative requesting the inspection, who may be accompanied by one other person of his or her choosing.

(b) Additionally, any patient or patient's representative shall be entitled to copies of all or any portion of the patient records that he or she has a right to inspect … .

[176] California Health & Safety Code § 123110(f) and (g).

Psychological Test Data

Psychologists are ethically obligated to protect test data. According to the American Psychological Association's *Code of Conduct,* "[p]sychologists refrain from misuse of assessment techniques, interventions, results, and interpretations and take reasonable steps to prevent others from misusing the information these techniques provide. This includes refraining from releasing raw test results or raw data to persons, other than to patients or clients as appropriate, who are not qualified to use such information."[177] Raw psychological test data include "standardized scores, including I.Q.s and percentiles," as well as "test scores, stimuli, and responses."[178]

In some cases, the psychologist's ethical duty to protect raw data collides with a legal duty to disclose client information. Tranel analyzes such conflicts and offers practical advice:

> The APA Ethical Principles prohibit the release of raw data to unqualified individuals, and with rare exceptions, attorneys are not qualified individuals. A viable course of action if an attorney should request raw data from a psychologist (A), would be to advise the attorney to engage the consultation of another psychologist (B), who is qualified, by virtue of licensure, training, and experience, to receive the data. Psychologist A then could send the raw data to Psychologist B (provided the client or patient has given appropriate consent). Psychologist B could then interpret the data to the attorney. Needless to say, Psychologist B must operate under the same rules and standards of ethics and confidentiality as Psychologist A.[179]

Subpoenas

This section discusses subpoenas. Before defining "subpoena," however, we need to define another word, "process." In law, "process" is the method courts use to assert their authority. A subpoena is one type of legal process.[180] The person who delivers a subpoena is usually called a "process server" (*i.e.*, process deliverer). In some cases, a subpoena is served by a law enforcement officer. Service by law enforcement is not always required, however.[181] Some subpoenas are served by mail.[182] A subpoena must be served far enough in advance to give the person subpoenaed enough time to respond.[183]

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[177] American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Standard 2.02(b)).

[178] D. Tranel, The Release of Psychological Data to Nonexperts: Ethical and Legal Considerations, 25 *Professional Psychological: Research and Practice* 33–38, at 34 and 37 (1994).

[179] D. Tranel, The Release of Psychological Data to Nonexperts: Ethical and Legal Considerations, 25 *Professional Psychological: Research and Practice* 33–38, at 35 (1994).

[180] "'Process' includes all writs, warrants, summons, and orders of courts of justice or judicial officers." California Government Code § 26660(a). The word "process" includes "a writ or summons issued in the course of judicial proceedings." California Code of Civil Procedure § 17(6).

A "summons" is the form of process that is served on the defendant in a civil case to give the defendant notice of the case and to give the court authority (called jurisdiction) over the defendant. B.E. Witkin, *California Procedure,* vol. 3, § 875, p. 1063 (4th ed. 1996) (San Francisco: Bancroft Whitney).

A "writ" is a court order that is issued in the name of the People of the State of California, and that is directed to an official who is responsible for carrying out the court's orders. California Code of Civil Procedure § 17(6). The use of writs — often called "writ practice" — is enormously complicated. The most famous writ, and the one you probably have heard of, is the writ of habeas corpus. A writ of habeas corpus directs an officer or person who has custody of a person such as a prisoner or a child to bring the person before the court.

[181] *See* California Code of Civil Procedure § 1987(a), which provides that "The service may be made by any person."

[182] *See* California Penal Code § 1328d, which provides that "a subpoena may be delivered by mail or messenger."

[183] In civil cases, "The service shall be made so as to allow the witness a reasonable time for preparation and travel to the place of attendance." California Code of Civil Procedure § 1987(a).

When a child is subpoenaed, the subpoena is served on the child's parent or guardian. If there is no parent or guardian, the subpoena is served on the person who has care and control of the child or the person with whom the child lives. If the child is twelve years old or older, the subpoena must also be served on the minor.[184]

There are two primary types of subpoenas: (1) a subpoena that requires a person to testify (called a subpoena *ad testificandum*), and (2) a subpoena that requires a person to produce records (called a subpoena *duces tecum*).[185] Sometimes, a subpoena requires testimony *and* production of records.

Subpoenas are used to compel attendance of witnesses and production of records in criminal cases,[186] civil cases,[187] juvenile court cases,[188] and in divorce and child custody proceedings.

A subpoena may be issued by a judge, a court clerk, or, in civil cases, an attorney.

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[184] *See* California Code of Civil Procedure § 1987(a); California Penal Code § 1328.

[185] In civil cases (but not juvenile court cases), a subpoena *duces tecum* must be accompanied by an affidavit that describes exactly what records are desired in response to the subpoena. California Code of Civil Procedure § 1985(b). "An affidavit is a written declaration under oath, made without notice to the adverse party." California Code of Civil Procedure § 2003. "The service of a subpoena duces tecum is invalid unless at the time of such service a copy of the affidavit upon which the subpoena is based is served on the person served with the subpoena." California Code of Civil Procedure § 1987.5.

The Evidence Code contains special rules regarding subpoenas *duces tecum* for business records. *See* California Evidence Code §§ 1560–1565.

[186] In criminal cases, "[t]he process by which the attendance of a witness before a court or magistrate is required is a subpoena." California Penal Code § 1326.

[187] In civil cases, "[t]he process by which the attendance of a witness is required is the subpoena." California Code of Civil Procedure § 1985(a).

[188] California Welfare & Institutions Code § 341 governs subpoenas in juvenile court dependency proceedings, and provides:

> Upon request of the social worker, district attorney, the child, or the child's parent, guardian, or custodian, or on the court's own motion, the court or the clerk of the court, or an attorney, pursuant to Section 1985 of the Code of Civil Procedure, shall issue subpoenas requiring the attendance and testimony of witnesses and production of papers at any hearing regarding a child who is alleged or determined by the court to be a person described in Section 300. [Section 300 defines child abuse and neglect].

California Welfare & Institutions Code § 664(a) governs subpoenas in juvenile court delinquency proceedings, and provides:

> The district attorney or the attorney for the minor may issue, and upon request of the probation officer, the minor, or the minor's parent, guardian, or custodian, the court or the clerk of the court shall issue, and, on the court's own motion, the court may issue, subpoenas requiring attendance and testimony of witnesses and production of papers at any hearing regarding a minor who is alleged or determined by the court to be a person described by Section 601 or 602. [Section 601 pertains to minors who persistently or habitually refuse to obey reasonable instructions, who violate curfew ordinances, and who are chronically truant from school. Section 602 defines juvenile delinquency].

Cal. Rule of Court 1408(d) applies to dependency and delinquency proceedings in juvenile court, and provides:

> On the court's own motion or at the request of the petitioner, child, parent, guardian, or present custodian, the clerk shall issue subpoenas requiring attendance and testimony of witnesses and the production of papers at a hearing.

Subpoenas Duces Tecum in Civil Cases

In civil cases, special rules govern subpoenas *duces tecum* for client records.[189] In addition to serving the subpoena on the professional, the subpoena must be served on the client or the client's attorney.[190] If the client is a child, the subpoena must be served on the child's "parent, guardian, conservator, or similar fiduciary, or if one of them cannot be located with reasonable diligence, then service shall be made on any person having the care or control of the [child] or with whom the [child] resides or by whom the [child] is employed, and on the [child] if the [child] is at least 12 years of age."[191] If the attorney who issued the subpoena *duces tecum* fails to serve it on the client or the client's attorney, the professional may refuse to produce the records.[192] The client may file objections to the subpoena, or may file a motion to quash the subpoena.[193]

The attorney who subpoenas client records may furnish the professional a written authorization to release the records signed by the client or the client's attorney.[194] The law allows the professional to "presume that any attorney purporting to sign the authorization on behalf of the [client] acted with the consent of the [client], and that any objection to release of records is waived."[195] Despite this assurance, it is recommended that the professional contact the client or the client's attorney to verify the authorization to release records.

The special rules described in this subsection apply only to civil cases. Thus, the special rules do not apply to subpoenas issued in criminal cases. In addition, the special rules described in this subsection do not apply to dependency or delinquency proceedings in Juvenile Court.[196]

Deposition Subpoenas in Civil Cases

When a civil lawsuit is filed in court, the attorneys engage in pretrial "discovery." The purpose of discovery is to learn as much as possible about the case. One of the most common discovery methods is the deposition. A deposition is testimony under oath.[197] The typical deposition takes place in a lawyer's office, not in court. Along with the witness — called the deponent — the lawyers for both sides attend and ask questions. The judge does not attend. The oath is administered by the court reporter who creates a verbatim record of the deposition.

If you are asked to attend a deposition, you should consult an attorney or your malpractice insurance carrier in advance. You may choose to be accompanied at the deposition by an attorney. The client should be informed. Many professionals insist that they be formally subpoenaed for a deposition. The subpoena is made part of the client's record.

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[189] *See* California Code of Civil Procedure § 1985.3.

[190] California Code of Civil Procedure § 1985.3(b).

[191] California Code of Civil Procedure § 1985.3(b)(1). The subpoena must be served on the client "Not less than 10 days prior to the date for production specified in the subpoena duces tecum, plus the additional time provided by Section 1013 if service is by mail." *Id.* at § 1985.3(b)(2).

[192] California Code of Civil Procedure § 1985.3(k). Refusal to produce records should be on the advice of an attorney.

[193] California Code of Civil Procedure § 1985.3(g).

[194] California Code of Civil Procedure § 1985.3(c)(2).

[195] California Code of Civil Procedure § 1985.3(c)(2).

[196] *See* Gary C. Seiser & Kurt Kumli, *California Juvenile Courts Practice and Procedure* (2001) (Lexis Publishing).

[197] *See* California Code of Civil Procedure § 2004, which states in part that "A deposition is a written declaration, under oath, made upon notice to the adverse party, for the purpose of enabling him to attend and cross-examine."

A deposition subpoena may require (1) only the presence of the witness for questioning, (2) only the production of records, or (3) both the presence of the witness and the production of records.[198]

Depositions are uncommon in criminal and juvenile court cases.[199]

Responding to a Subpoena

A subpoena is a court order and cannot be ignored. Disobedience of a subpoena can be punished as contempt of court,[200] and can lead to a fine.[201] Although a subpoena cannot be ignored, neither should a subpoena be unthinkingly obeyed. Tranel writes that "psychologists need not automatically translate the serving of a subpoena into prompt acquiescence to legal demands without regard for the ethics of the matter."[202] After all, some subpoenas are invalid.[203]

Before you comply with a subpoena, consider the following:

Should I Contact the Client Before I Respond to a Subpoena?

A client cannot override a professional's duty to respond to a subpoena. Nevertheless, the client should be consulted before responding to a subpoena. If the client is a child, consultation should occur with the child's parent or the adult with legal responsibility for the child. If the child is sufficiently mature, the child should be consulted. When the child is twelve or older, it is generally appropriate to consult the child. Some children under twelve are sufficiently mature to merit consultation. If the child has an attorney, the attorney should be consulted.

When discussing a subpoena with a client or the client's attorney, describe what information has been requested through the subpoena and by whom. The client should understand what, if any, confidential information may be released. The client should also understand that release of information that meets the requirements of a privilege such as the psychotherapist-patient privilege could jeopardize future application of the privilege. The client needs to know who will have access to released information, and where the information will be stored. "Following such a discussion, a legally competent client or the client's legal

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198 California Code of Civil Procedure § 2020(a).

199 *See* Gary C. Seiser & Kurt Kumli, *California Juvenile Court Practice and Procedure* § 2.109[1] (2001).

200 *See* California Code of Civil Procedure § 1991 provides that "Disobedience to a subpoena, or a refusal to be sworn as a witness, or to subscribe an affidavit or deposition when required, may be punished as a contempt by the court issuing the subpoena." *See also* California Code of Civil Procedure § 2020(h), which refers to deposition subpoenas, and provides that "A deponent who disobeys a deposition subpoena in any manner described in subdivision (g) may be punished for contempt under Section 2023 without the necessity of a prior order of court directing compliance by the witness, and is subject to the forfeiture and the payment of damages set forth in Section 1992. *See also* California Penal Code § 1331, which provides that "Disobedience to a subpoena, or a refusal to be sworn or to testify as a witness, may be punished by the Court or magistrate as a contempt."

201 *See* California Code of Civil Procedure § 1992 provides that "A witness disobeying a subpoena also forfeits to the party aggrieved the sum of five hundred dollars ($500), and all damages which he may sustain by the failure of the witness to attend, which forfeiture and damages may be recovered in a civil action." In other words, you could be sued. *See also* California Penal Code § 1331, which provides that "A witness disobeying a subpoena issued on the part of the defendant, unless he show good cause for his nonattendance, is liable to the defendant in the sum of one hundred dollars, which may be recovered in a civil action."

202 D. Tranel, The Release of Psychological Data to Nonexperts: Ethics and Legal Considerations, 25 *Professional Psychology: Research and Practice* 33–38, at 36 (1994).

203 A subpoena may be completely or partially invalid.

guardian may choose to consent in writing to production of the data."[204] Getting the client's consent in writing "may avoid future conflicts or legal entanglements with the client over the release of confidential" information.[205]

When the client is a child, the discussion described above typically takes place with an adult. The child's therapist owes it to the child to make sure the adult's decision about the subpoena is in the child's best interest.

As stated above, professionals cannot ignore subpoenas. Yet, blind obedience to subpoenas can cause problems. Consider the unusual case in which a psychologist was disciplined for *complying* with a subpoena.[206] The psychologist supervised an unlicensed therapist who provided treatment to a child suffering chronic headaches. The headaches were allegedly caused by a fall at a community center. The child's mother sued the community center. Some time later, the attorney for the community center mailed a subpoena to the supervising psychologist requesting the child's treatment records. Without contacting the child, the child's mother, or the child's attorney, the psychologist gave the child's treatment records to the community center's attorney. Although the mother had previously given permission to disclose the child's records to the *child's* attorney, no permission had been given to disclose the records to anyone else. The state board of psychology disciplined the psychologist. The psychologist appealed to a court, but the judges agreed with the board of psychology. The judges wrote that the psychologist "had a duty to either obtain written permission to release the records from [the child] or challenge the propriety of the subpoena before a judge. [The psychologist] did neither. Instead, she unilaterally gave [the child's] records to [the attorney for the community center] without consulting with [the child] or her attorney."[207] Moral of the story? Consult the client, the client's attorney, and, if you have an attorney, your attorney *before* responding to a subpoena.

Should I Get Legal Advice?

If you have any doubt about what to do, consult an attorney *before* you comply with a subpoena. Do not accept "legal" advice from someone who is not an attorney. If you work for a government agency, consult legal counsel for the agency. Hospitals and some clinics have an attorney on staff or on retainer. Professionals in private practice should retain an attorney, talk to an attorney they know, or contact their malpractice insurance carrier.[208] If the child has an attorney, consult the child's attorney. In criminal cases, the prosecutor may be a good source of advice on responding to a subpoena from the defense. In juvenile court dependency cases, the Deputy County Counsel handling the child's case may be consulted. In most dependency cases, the child has an attorney of their own.

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[204] Committee on Legal Issues of the American Psychological Association, Strategies for Private Practitioners Coping with Subpoenas or Compelled Testimony for Client Records or Test Data, 27 *Professional Psychology: Research and Practice* 245–251, at 246 (1996). The Committee wrote:

> When appropriate, the psychologist may consult with the client's attorney. This discussion will inform the client which information has been demanded, the purpose of the demand, the entities or individuals to whom the information is to be provided, and the possible scope of further disclosure by those entities or individuals.

Id.

[205] *Id*.

See Stephen H. Behnke, James Preis & R. Todd Bates, *The Essentials of California Mental Health Law: A Straightforward Guide for Clinicians of All Disciplines* p. 33 (1998) (New York: W. W. Norton) ("A patient's consent to release confidential information should be in writing.").

[206] Rost v. State Board of Psychology, 659 A.2d 626 (Pa. Commonwealth Ct. 1995).

[207] *Id*. at 629.

[208] *See* Stephen H. Behnke, James Preis & R. Todd Bates, *The Essentials of California Mental Health Law: A Straightforward Guide for Clinicians of All Disciplines* p. 62 (1998) (New York: W. W. Norton) ("It is wise to consult your malpractice carrier any time you testify, to determine whether presence of a lawyer is indicated. If you receive a subpoena, be sure to check with your malpractice carrier and follow their advice on whether you should have legal representation.").

Professional organizations like the American Psychological Association and the National Association of Social Workers dispense useful information. So too do government agencies like the State Board of Psychology. Generally speaking, however, these organizations and agencies do not give legal advice.

Should I Talk to the Attorney Who Issued the Subpoena?

The one attorney who is not in a position to give objective advice about a subpoena is the attorney who issued the subpoena. A few attorneys get downright tricky. In one case, for example, a therapist received a subpoena stating: "You are hereby commanded to send Jane Doe's entire treatment record to the D.A.'s office, 13265 Flint Blvd, City." The therapist did a little checking and found out that "D.A." stood for Defense Attorney! The defense attorney issued the subpoena intending to mislead the therapist into thinking the subpoena came from the District Attorney.

Do not get the impression that you should never talk to the attorney who issued a subpoena. Before doing so, however, get the client's consent. When the client is a child, obtain consent from the child's parent or the person with legal authority to consent. When the child is sufficiently mature, get the child's consent. If the child has an attorney, consult the attorney.

When you talk to the attorney who issued the subpoena, it is usually possible to avoid revealing confidential information. The Committee on Legal Issues of the American Psychological Association recommends that discussions with the attorney who issued the subpoena "explore whether there are ways to achieve the requesting party's objectives without divulging confidential information, for example, through disclosure of nonconfidential materials or submission of an affidavit by the psychologist disclosing nonconfidential information."[209] In some cases, discussion between a therapist and an attorney helps the attorney realize the therapist has nothing useful, and the subpoena is withdrawn. In other cases, discussion narrows the information requested.

A person who is subpoenaed to testify in court may agree with the attorney issuing the subpoena to change the time of the testimony.[210]

The attorney who issued the subpoena can confirm the time and place for testimony, along with other details.[211]

What if the Client Does Not Want Me to Respond to the Subpoena?

As stated above, a client cannot override the duty to respond to a subpoena. At the same time, however, some subpoenas are invalid, and can be resisted. For example, a subpoena may seek disclosure of information that is protected by the psychotherapist-patient privilege. A subpoena does *not* override

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[209] Committee on Legal Issues of the American Psychological Association, Strategies for Private Practitioners Coping with Subpoenas or Compelled Testimony for Client Records or Test Data, 27 *Professional Psychology: Research and Practice* 245–251, at 246 (1996).

[210] *See* California Code of Civil Procedure § 1985.1, which provides in part:

> Any person who is subpoenaed to appear at a session of court, or at the trial of an issue therein, may, in lieu of appearance at the time specified in the subpoena, agree with the party at whose request the subpoena was issued to appear at another time or upon such notice as may be agreed upon.

See also California Penal Code § 1331.5, which is identical to California Code of Civil Procedure § 1985.1, above.

[211] *See* California Code of Civil Procedure § 1985.2, which provides:

> Any subpoena which requires the attendance of a witness at any civil trial shall contain the following notice in a type face designed to call attention to the notice:
>
> Contact the attorney requesting this subpoena, listed above, before the date on which you are required to be in court, if you have any question about the time or date for you to appear, or if you want to be certain that your presence in court is required.

this privilege. Sometimes the client is too young to decide, yet the adults in the child's life are not making responsible decisions. What to do? If the client wants to resist the subpoena, or if resistance is in a child's best interest, the appropriate action is to file a motion in court to quash the subpoena.[212] A motion to quash a subpoena may be filed by the child's attorney, the prosecutor, county counsel, or the therapist's attorney.

When a motion to quash is filed, a judge decides whether the subpoena is valid.[213] The therapist may have to testify at the hearing on the motion to quash. If the judge quashes the subpoena, the therapist does not have to respond. The judge may decide, for example, that records sought by the subpoena are privileged. On the other hand, if the judge rules that the subpoena is valid, the therapist must comply or risk being held in contempt of court.

Instead of a motion to quash, the Committee on Legal Issues of the American Psychological Association suggests that the professional may wish to write to the judge, sending a copy of the letter to the lawyers.[214] The Committee writes:

> The simplest way of proceeding, and perhaps the least costly, may be for the psychologist (or his or her attorney) to write a letter to the court, with a copy to the attorneys for both parties, stating that the psychologist wishes to comply with the law but that he or she is ethically obligated not to produce the confidential records or test data or to testify about them unless compelled to do so by the court or with the consent of the client. In writing such a letter, the psychologist (or his or her lawyer) may request that the court consider the psychologist's obligations to protect the interests of the client, the interests of third parties (e.g., test publishers or others), and the interests of the public in preserving the integrity and continued validity of the tests themselves. This letter may help sensitize the court about the potential adverse effects of dissemination. The letter might also attempt to provide suggestions, such as the following, to the court on ways to minimize the adverse consequences of disclosure if the court is inclined to require production at all:
>
> 1. Suggest that, at most, the court direct the psychologist to provide test data only to another appropriately qualified psychologist designated by the court or by the party seeking such information.
>
> 2. Suggest that the court limit the use of client records or test data to prevent wide dissemination. For example, the court might order that the information be delivered, be kept under seal, and be used solely for the

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[212] A motion is a written request to the court for an order or other action. The term motion includes an informal written request to the court, such as a letter. California Code of Civil Procedure § 116.130(h). Section 1003 of the California Code of Civil Procedure provides that "An application for an order is a motion."

[213] *See* California Code of Civil Procedure § 1987.1, which provides:

> When a subpoena requires the attendance of a witness or the production of books, documents or other things before a court, or at the trial of an issue therein, or at the taking of a deposition, the court, upon motion reasonably made by the party, the witness, or any consumer described in Section 1985.3, or upon the court's own motion after giving counsel notice and an opportunity to be heard, may make an order quashing the subpoena entirely, modifying it, or directing compliance with it upon such terms or conditions as the court shall declare, including protective orders. In addition, the court may make any other order as may be appropriate to protect the parties, the witness, or the consumer from unreasonable or oppressive demands including unreasonable violations of a witness's or consumer's right of privacy. Nothing herein shall require any witness or party to move to quash, modify, or condition any subpoena duces tecum of personal records of any consumer served under paragraph (1) of subdivision (b) of Section 1985.3.

[214] Committee on Legal Issues, American Psychological Association, Strategies for Private Practitioners Coping With Subpoenas or Compelled Testimony for Client Records or Test Data, 27 *Professional Psychology: Research and Practice* 245–251 (1996).

purposes of the litigation and that all copies of the data be returned to the psychologist under seal after the litigation is terminated. The order might also provide that the requester may not provide the information to any third parties.

3. Suggest that the court limit the categories of information that must be produced. For example, client records may contain confidential information about a third party, such as a spouse, who may have independent interests in maintaining confidentiality, and such data may be of minimal or no relevance to the issues before the court. The court should limit its production order to exclude such information.

4. Suggest that the court determine for itself, through in camera proceedings (i.e., a nonpublic hearing or a review by the judge in chambers), whether the use of the client records or test data is relevant to the issue before the court or whether it might be insulated from disclosure, in whole or in part, by the therapist-client privilege or another privilege.[215]

What if My Client Receives a Subpoena and Calls Me for Advice?

Needless to say, mental health and medical professionals do not give legal advice. For legal advice, the client is referred to a lawyer. The professional may work with the lawyer. Of course, the professional helps the client deal with the psychological aspects of testifying.

Confidential Addresses for Adult Victims of Domestic Violence or Stalking

An adult victim of domestic violence or stalking may apply to the California Secretary of State for a confidential address.[216] When a confidential address is approved, subpoenas and other legal process are sent to the confidential address.

Dual Roles

Should mental health professionals providing psychotherapy agree to perform forensic evaluations of their therapy clients? Are the therapeutic and forensic roles incompatible? For example, should the psychotherapist for a child whose parents are divorcing agree to perform a custody evaluation of the entire family? Should a psychotherapist who is treating a child for the effects of sexual abuse agree to conduct a formal forensic assessment of abuse and testify in court regarding the findings of the assessment?

Although there are few pat answers to such questions, the literature sheds light on the subject. Greenberg and Shuman write that "a role conflict arises when a treating therapist also attempts to testify as a forensic expert addressing the psycholegal issues in the case."[217] Melton and his colleagues add that "forensic assessment differs from a therapeutic assessment on a number of dimensions."[218] The American Professional Society on the Abuse of Children notes that "forensic evaluations are different from clinical evaluations in generally requiring a different professional stance and additional components."[219]

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[215] *Id.* at 247.

[216] California Government Code §§ 6205-6211.

[217] S.A. Greenberg & D.W. Shuman, Irreconcilable Conflict Between Therapeutic and Forensic Roles, 28 *Professional Psychology: Research and Practice* 50–57, at 50 (1997).

[218] G.B. Melton, J. Petrila, N. Poythress & C. Slobogin, *Psychological Evaluations for the Courts* p. 42 (2nd ed. 1997) (New York: Guilford).

[219] American Professional Society on the Abuse of Children, *Guidelines for Psychosocial Evaluation of Suspected Sexual Abuse in Young Children* (1996) (Chicago: American Professional Society on the Abuse of Children).

Ethics codes emphasize the potential conflict between therapeutic and forensic roles. The *Code of Conduct* of the American Psychological Association states that "[i]n most circumstances, psychologists avoid performing multiple and potentially conflicting roles in forensic matters."[220] The Specialty Guidelines for Forensic Psychologists state:

> Forensic psychologists recognize potential conflicts of interest in dual relationships with parties to legal proceedings, and they seek to minimize their effects. Forensic psychologists avoid providing professional services to parties in a legal proceeding with whom they have personal or professional relationships that are inconsistent with the anticipated relationship. When it is necessary to provide both evaluation and treatment services to a party in a legal proceeding (as may be the case in small forensic hospital settings or small communities), the forensic psychologist takes reasonable steps to minimize the potential negative effects of these circumstances on the rights of the party, confidentiality, and the process of treatment and evaluation.[221]

The ethical guidelines of the American Academy of Psychiatry and the Law provide that "[t]reating psychiatrists should generally avoid agreeing to be an expert witness or to perform evaluations of their patients for legal purposes because a forensic evaluation usually requires that other people be interviewed and testimony may adversely affect the therapeutic relationship."[222] The Committee on Psychiatry and Law of the Group for the Advancement of Psychiatry states that "[w]hile, in some areas of the country with limited numbers of mental health practitioners, the therapist may have the role of forensic expert thrust upon him, ordinarily, it is wise to avoid mixing the therapeutic and forensic roles."[223] The *Code of Ethics* of the American Professional Society on the Abuse of Children provides:

> Clear definitions of professional roles, responsibilities, duties, and tasks and the limits of professional conduct provide clients with maximal information upon which to base their own decisions and actions. The nature of child maltreatment, in which boundaries are blurred or broken, relationships are disturbed, and social positions such as parent, caregiver, and helper are perverted, makes the maintenance of clear professional relationships with patients all the more critical for client protection and in creating the optimal conditions for growth and development. … When a professional is called upon to engage in more than one professional role, such as therapist and advocate, investigator and therapist, assessor and healer, investigator and concerned citizen, the professional must be clear about the different responsibilities and tasks required for each role; take appropriate steps to guard against role conflict; and make sure that the client understands the nature and different responsibilities of each role. Assuming more than one professional role in a given case at a given time does not necessarily represent an unethical multiple-role relationship.[224]

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[220] American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Principle 7.03).

[221] American Psychological Association, Committee on Ethical Guidelines for Forensic Psychologists, Specialty Guidelines for Forensic Psychologists, 15 *Law and Human Behavior* 655–665, at 659 (1991).

[222] American Academy of Psychiatry and the Law, Ethical Guidelines for the Practice of Forensic Psychiatry, in *Membership Directory of the American Academy of Psychiatry and the Law* p. xiv (1995) (Bloomfield, CT: American Academy of Psychiatry and the Law).

[223] Committee on Psychiatry and Law, Group for the Advancement of Psychiatry, *The Mental Health Professional and the Legal System* p. 44 (1991) (Rep. No. 131) (New York: Brunner/Mazel).

[224] American Professional Society on the Abuse of Children, *Code of Ethics* p. 3 (1997) (Chicago: IL: American Professional Society on the Abuse of Children).

Ethical guidelines for professionals performing child custody evaluations in divorce cases are quite specific regarding the potential conflict between forensic and treatment roles. The *Model Standards of Practice* of the Association of Family and Conciliation Courts provide that "a person who has been a mediator or a therapist for any or all members of the family should not perform a custody evaluation because the previous knowledge and relationships may render him or her incapable of being completely neutral and incapable of having unbiased objectivity."[225] The *Guidelines for Child Custody Evaluations in Divorce Proceedings* of the American Psychological Association provide that "[p]sychologists generally avoid conducting a child custody evaluation in a case in which the psychologist served in a therapeutic role for the child or his or her immediate family or has had other involvement that may compromise the psychologist's objectivity."[226]

A child's therapist can provide useful information to the courts without crossing the line into dual roles. For example, the therapist may provide information about the child's progress in therapy, the child's current level of functioning, and the child's feelings about various adults. If the child made legally relevant disclosures during treatment, the therapist may repeat those statements in court.[227]

For excellent guidelines on conducting psychological evaluations in dependency cases, see the guidelines prepared by the American Psychological Association.[228]

Reporting Child Abuse

Mental health and medical professionals are ethically[229] and legally[230] required to report suspected child abuse and neglect, including physical abuse, sexual abuse, neglect, and willful cruelty or unjustifiable punishment causing physical pain or mental suffering.[231] A report is required when a professional, in the course of their

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[225] Association of Family and Conciliation Courts, Model Standards of Practice, 32 *Family and Conciliation Courts Review* 504–513 (1994) (Principle VI.B).

[226] American Psychological Association, Guidelines for Child Custody Evaluations in Divorce Proceedings, 49 *American Psychologist* 677-680 (1994) (Guideline 7).

See J.B. Glassman, Preventing and Managing Board Complaints: The Downside Risk of Custody Evaluation, 29 *Professional Psychology: Research and Practice* 121–124 (1998) ("Changing roles from therapist to custody evaluator will most likely be interpreted as an ethics violation.").

[227] The child's statements during treatment are hearsay, but whether hearsay is admissible in court is an issue for the judge and lawyers to decide, not the therapist.

[228] Committee on Professional Practice and Standards, APA Board of Professional Affairs, Guidelines for Psychological Evaluations in Child Protection Matters, *54 American Psychologist*, 586–593 (1999).

[229] *See Barclays Official California Code of Regulations,* vol. 21, Title 16, § 1397.1 (1997) (Board of Psychology: "Failure to comply with the reporting requirements contained in Penal Code Section 11166" shall constitute unprofessional conduct.); *id.* § 1845(c) (1999) (Marriage and Family Therapists: "Failure to comply with the child abuse reporting requirements of Penal Code Section 11166" is unprofessional conduct); *id.* § 1858(o) (1999) (Educational Psychologists: "Failure to comply with the child abuse reporting requirements of Penal Code Section 11166" is unprofessional conduct.); *id.* § 1881(o) (1999) (Licensed Clinical Social Workers: "Failure to comply with the child abuse reporting requirements of Penal Code Section 11166" is unprofessional conduct).

[230] California's child abuse reporting law is located in the Penal Code. *See* California Penal Code §§ 11164 to 11174.3. The reporting law covers every professional who comes in contact with children. The reporting law defines abuse and neglect broadly, to include sexual abuse, physical abuse, and neglect.

[231] California Penal Code § 11165.6.

work,[232] (1) observes first hand a child who may be abused or neglected, or (2) does not actually observe the child, but acquires information that the child may have been abused or neglected.[233]

Reporting is required when the professional "knows or reasonably suspects" a child has been abused or neglected.[234] Reasonable suspicion "means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her experience, to suspect child abuse or neglect."[235] Put another way, reporting is required when a professional has information that would lead a competent professional to suspect abuse or neglect is reasonably likely.

Unfortunately, it is not possible to define "reasonable suspicion" in a way that answers all questions in advance. In some cases reporting is obvious. In others, the professional struggles with the decision. In the final analysis, reasonable suspicion depends on the facts of each case, as interpreted through experience and judgment.

It is important to remember that the duty to report does not require the professional to "know" abuse or neglect occurred. All that is required is reasonable suspicion. The law requires reporting of suspicion, not certainty. A professional who postpones reporting until all doubt is eliminated violates the reporting law.[236] The law deliberately leaves the ultimate decision about maltreatment to investigating officials, not reporters. Thus, Kalichman advises that "therapists should avoid acting as investigators and restrict their actions within proper roles."[237] Zellman and Faller add that "reporting laws ask professionals to be reasonably vigilant and to report their suspicions or beliefs that maltreatment occurred or is occurring. The laws are clear that no more is required: Indeed, professionals are precluded explicitly from conducting any further investigation, a prohibition reinforced by the short latency period before a report is required."[238] This is not to say that professionals should ask no questions and consider no alternatives to abuse. The point is that in-depth investigation is the bailiwick of law enforcement and child protective services, not reporters.

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[232] *See* California Penal Code § 11166(a), which provides that a mandated reporter file a report "whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes" child abuse or neglect.

See also 72 Opinions of the California Attorney General 216 (1989) (the reporting law accomplishes its goal of child protection "by requiring certain categories of persons whose occupations place them in contact with children to report to a 'child protective agency' when, in the course of their work, they come to know or reasonably suspect that someone under the age of eighteen has been a victim of child abuse.").

[233] California Penal Code § 11166(a). The statute requires a report "whenever a mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect."

[234] *Id.*

[235] California Penal Code § 11166(a)(1). This section also states that "the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse."

[236] Failure to obey the reporting law is a misdemeanor. California Penal Code § 11166(b) provides that "Any mandated reporter who fails to report an instance of known or reasonably suspected child abuse or neglect is guilty of a misdemeanor … ."

Failure to report can result of a lawsuit against the professional. *See* Landeros v. Flood, 17 Cal. 3d 399 (1976); John E.B. Myers, *Legal Issues in Child Abuse and Neglect Practice* (2nd ed. 1998) (Thousand Oaks, CA: Sage).

[237] Seth C. Kalichman, *Mandated Reporting of Suspected Child Abuse: Ethics, Law, and Policy* p. 154 (1993) (Washington, D.C.: American Psychological Association).

[238] Gail L. Zellman & Kathleen Coulborn Faller, Reporting of Child Maltreatment, in John Briere, Lucy Berliner, Josephine A. Bulkley, Carole Jenny & Theresa Reid (Eds.). *The APSAC Handbook on Child Maltreatment* pp. 359–381, at 365 (1996) (Thousand Oaks, CA: Sage).

The professional must report by phone to a police or sheriff's department or county child protective agency immediately or as soon as practically possible.[239] The telephone report must be followed by a written report within 36 hours of receiving information about possible maltreatment. The reporter's name is confidential.[240]

When two or more professionals know of or suspect abuse, one may make the report.[241] Within agencies and institutions, procedures for reporting may be established.[242] The law provides, however, that "[t]he reporting duties … are individual, and no supervisor or administrator may impede or inhibit the reporting duties, and no person making a report shall be subject to any sanctions for making the report."[243] Moreover, procedures for reporting within agencies and institutions "shall not require any employee required to make reports pursuant [to the reporting law] to disclose his or her identity to the employer."[244]

Reporting is mandatory.[245] If the triggering level of suspicion exists, a professional has *no* discretion in the matter: A report must be made.

The duty to report child abuse overrides the ethical duty of confidentiality. Additionally, the duty to report overrides the psychotherapist-patient and other privileges.[246]

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[239] *See* California Penal Code § 11165.9. Section 11167 provides:

> (a) Reports of suspected child abuse or neglect pursuant to Section 11166 shall include, if known, the name, business address, and telephone number of the mandated reporter, and the capacity that makes the person a mandated reporter; the child's name and address, present location, and, where applicable, school, grade, and class; the names, addresses, and telephone numbers of the child's parents or guardians; the information that gave rise to the reasonable suspicion if child abuse or neglect and the source or sources of that information; and the name, address, telephone number, and other relevant personal information about the person or persons who might have abused or neglected the child. The mandated reporter shall make a report even if some of this information is not known or is uncertain to him or her.
>
> (b) Information relevant to the incident of child abuse or neglect may also be given to an investigator from an agency that is investigating the known or suspected case of child abuse or neglect.
>
> (c) Information relevant to the incident of child abuse or neglect, including the investigation report and other pertinent materials, may be given to the licensing agency when it is investigating a known or suspected case of child abuse or neglect.

[240] California Penal Code § 11167(d)(1).

[241] *See* California Penal Code § 11166(f), which provides:

> When two or more persons who are required to report, jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

[242] California Penal Code § 11166(g)(1).

[243] California Penal Code § 11166(g)(1).

[244] California Penal Code § 11166(g)(2).

[245] California Penal Code § 11166(a). *See* Seth C. Kalichman, *Mandated Reporting of Suspected Child Abuse: Ethics, Law, and Policy* p. 153 (1993) (Washington, D.C.: American Psychological Association).

[246] *See* 65 Opinions of the California Attorney General 345 (1982) (the reporting requirement of the child abuse reporting law overrides the confidentiality provisions of § 5328 of the Lanterman-Prentis-Short Act.).

See also California Evidence Code § 1027, which provides that the psychotherapist-patient privilege does not apply when the client is under the age of 16 and "[t]he psychotherapist has reasonable cause to believe that the patient has been the victim of a crime and that disclosure of the communication is in the best interest of the child."

A professional who makes a report of child abuse is immune from civil or criminal liability.[247] Although the immunity provision of the reporting law is critical, professionals must understand that the immunity provision cannot prevent a lawsuit from being filed. The immunity provision gives the professional a way out of a lawsuit, but cannot prevent a lawsuit in the first place.[248]

Documentation

Documentation is important to treatment. In addition, "failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered" can lead to disciplinary action by state licencing authorities.[249]

Documentation is vital to risk management. "[I]f you become involved in a lawsuit, you are likely to be deemed as behaving unprofessionally if you have not kept adequate records."[250] Malpractice attorneys have a maxim: "If it isn't in writing, it didn't happen."[251] Reid writes, "Whoever started the rumor in professional circles that 'if you don't write it down, they can't hang you with it' was dead wrong. In far more cases than not, legible notes help clinicians whose care is questioned."[252] Berner adds that "there is more than one way to assure self-destruction, and keeping no notes is one of those ways."[253] Thorough, accurate, ongoing documentation is a powerful defense against charges of improper practice.[254] Consultation with colleagues and supervision should be noted in the client's file.[255]

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[247] California Penal Code § 11172.

[248] For detailed discussion of immunity see John E.B. Myers, *Legal Issues in Child Abuse and Neglect Practice* (2nd ed. 1998) (Thousand Oaks, CA: Sage).

[249] California Business and Professions Code § 4982(v) (marriage and family therapists); 49986.70(I) (licensed educational psychologists); § 4992.3(s) (social workers).

See also Rafael A. Rivas-Vazquez, Mark A. Blais, Gustavo J. Rey and Ana A. Rivas-Vazquez, A Brief Reminder About Documenting the Psychological Consultation, 32 *Professional Psychology: Research and Practice* 194–199 (2001).

See also American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (1992) (Principle 1.23(b) provides: "When psychologists have reason to believe that records of their professional services will be used in legal proceedings involving recipients of or participants in their work, they have a responsibility to create and maintain documentation in the kind of detail and quality that would be consistent with reasonable scrutiny in an adjudicative forum.").

[250] Mary E. Moline, George T. Williams & Kenneth M. Austin, *Documenting Psychotherapy: Essentials for Mental Health Professionals* p. 4 (1998) (Thousand Oaks, CA: Sage).

[251] S. Knapp & L. VandeCreek, Risk Management for Psychologists: Treating Patients Who Recover Lost Memories of Childhood Abuse, 27 *Professional Psychology: Research and Practice* 452–459 (1996).

[252] William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed With Caution* p. 12 (1999) (Phoenix, AZ: Zeig, Tucker & Co).

[253] Marilyn Berner, Write Smarter, Not Longer, in Lawrence E. Lifson & Robert I. Simon (Eds.), *The Mental Health Practitioner and the Law: A Comprehensive Handbook* p. 68 (1998) (Cambridge, MA: Harvard University Press).

[254] *See* E.A. Harris, The Importance of Risk Management in a Managed Care Environment, in M.B. Sussman (Ed.), *A Perilous Calling: The Hazards of Psychotherapy Practice* (1995) (New York: John Wiley); Mary E. Moline, George T. Williams & Kenneth M. Austin, *Documenting Psychotherapy: Essentials for Mental Health Practitioners* p. 8 (1998) (Thousand Oaks, CA: Sage) ("Properly kept records can favorably influence the outcome of a malpractice suit.").

[255] *See* Mary E. Moline, George T. Williams & Kenneth M. Austin, *Documenting Psychotherapy: Essentials for Mental Health Practitioners* p. 45 (1998) (Thousand Oaks, CA: Sage) ("We believe that notes need to be made of all consultations so as to establish a professional 'standard of care.'").

Do not alter records.[256] As Berner puts it: "Never, Ever Change a Record."[257] Smith adds that "[t]his is particularly true once litigation involving the records is anticipated."[258] Of course, records can be corrected. Corrections, however, should be noted as such.[259] Berner offers the following advice:

> *Never, ever, change a record*, is not the same as Never, ever make a mistake. The issue here is how to correct a mistake in the record without breaking [the principle against changing records]. Corrections should be in real time, contemporaneously labeled, and transparent. This means that you should not attempt to make the record look as if there never had been a mistake in it. When you discover a mistake, you must acknowledge it and then correct it. This [is] what we mean by "real time." "Contemporaneously labeled" means that you must write "error" in the margin of the note, to alert the reader to both the existence of the error and the subsequent correction. "Transparent" means that the correction should refer to the site of the error but not hide it. It means no whiteout and no indelible black magic marker.[260]

In California, it is a misdemeanor to alter or modify medical records with fraudulent intent.[261] Reid notes that "[d]eleting or altering material to hide liability or criminal activity may well be a crime in itself."[262]

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[256] *See* William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed With Caution* p. 12 (1999) (Phoenix, AZ: Zeig, Tucker & Co) ("*Do not* change your notes after the fact except by adding *and dating* additional or explanatory information, or flagging inaccuracies by drawing a line through them.").

[257] Marilyn Berner, Write Smarter, Not Longer, in Lawrence E. Lifson & Robert I. Simon (Eds.), *The Mental Health Practitioner and the Law: A Comprehensive Handbook* p. 67 (1998) (Cambridge, MA: Harvard University Press).

[258] S.R. Smith, Malpractice Liability of Mental Health Professionals and Institutions, in B.D. Sales & D.W. Shuman (Eds.), *Law, Mental Health, and Mental Disorder* p. 92 (1996) (Pacific Grove, CA: Brooks/Cole).

[259] *See* Stephen H. Behnke, James Preis & R. Todd Bates, *The Essentials of California Mental Health Law: A Straightforward Guide for Clinicians of All Disciplines* p. 149 (1998) (New York: W.W. Norton), where the authors write:

> It sometimes happens that you or your client discover inaccuracies or mistakes in the record. While you cannot alter the record, you also do not want to perpetuate inaccurate clinical information. If you become aware of a mistake in the record, you may make an additional entry. In the entry, note the date of the mistaken information, explain that previously recorded information is inaccurate, provide the accurate information, and then date the entry according to when it is written. You may make a notation to the entry with the mistaken information, such as "See note of September 18, 1998, for correction." Initial and date this notation. In this manner you are adding correct information to, rather than altering, the record.

[260] Marilyn Berner, Write Smarter, Not Longer, in Lawrence E. Lifson & Robert I. Simon (Eds.), *The Mental Health Practitioner and the Law: A Comprehensive Handbook* p. 67 (1998) (Cambridge, MA: Harvard University Press).

[261] California Penal Code § 471.5 ("Any person who alters or modifies the medical record of any person, with fraudulent intent, or who, with fraudulent intent, creates any false medical record, is guilty of a misdemeanor.").

[262] William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed With Caution* p. 13 (1999) (Phoenix, AZ: Zeig, Tucker & Co).

Some professionals keep two sets of records. So-called "process" or "private" records are nevertheless part of the client's record, and are governed by the same "Do Not Alter Records" advice outlined above. Moreover, "process" or "private" records have to be disclosed in response to a lawful subpoena or court order.[263] Reid writes:

> The record is the record, and includes private or "process" notes that are not kept with the main file. Keeping a second, more private set of notes may be a good idea to protect the patient's revelations from the prying eyes of secretaries, medical records personnel, or other clinicians; however, the second set is no more privileged than the main file when your record is subpoenaed. Do not attempt to hide private notes.[264]

How long should client records be maintained?

Client records should be maintained as long as possible. At a minimum, records on adults should be retained for seven years following termination of treatment. With children, records should be retained, at a minimum, three years following the child's eighteenth birthday.[265]

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[263] *See* William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed With Caution* (1999) (Phoenix, AZ: Zeig, Tucker & Co).

[264] William H. Reid, *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed With Caution* p. 97 (1999) (Phoenix, AZ: Zeig, Tucker & Co).

[265] *See* American Psychological Association, Reports of the Association, Record Keeping Guidelines, 48 *American Psychologist* 984–986 (1993).